Report to Congress

Medicaid and Institutions for Mental Diseases

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December 1992
HCFA Pub. No. 03339

Acknowledgments

This report was prepared by the Office of Research of the Health Care Financing Administration (HCFA), George Schieber, Ph.D., Director. Jeffrey A. Buck, Ph.D., was the project officer for the study and the primary author of the report. Thomas Ashman of HCFA's Medicaid Bureau developed the history of the IMD policy (Chapter II). Charles A. Kiesler, Ph.D., and Celeste G. Simpkins of Vanderbilt University conducted the reviews of service system trends and the cost-effectiveness of services (Chapters IV and V). Richard G. Frank, Ph.D., and David Salkever, Ph.D., of Johns Hopkins University analyzed Medicaid expenditures for ADM services and estimated the costs of eliminating the IMD policy (Chapters VI and VII). Staff of the Alcohol, Drug Abuse, and Mental Health Administration, particularly Susan Farrell and Ronald Manderscheid, Ph.D., furnished helpful information concerning facility inventories and outcome research. Howard H. Goldman, M.D., Ph.D., of the University of Maryland, and Constance Horgan, Sc.D., of Brandeis University reviewed and provided useful comments on the draft report. Winona Hocutt of HCFA's Medicaid Bureau and Thomas Hoyer of HCFA's Bureau of Policy Development also contributed material.

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Since the beginning of the Medicaid program, medical assistance has been excluded for certain patients in institutions for mental diseases (IMDs). As currently defined, an IMD is any facility of more than 16 beds that specializes in psychiatric care. Generally, State mental hospitals, private psychiatric hospitals, and residential substance abuse programs are all examples of IMDs. Individual facilities not usually considered to be IMDs, such as nursing homes, may be so designated if they meet the definitional criteria.

The intent and scope of the IMD exclusion have been sources of controversy between the States and the Federal Government. Under section 6408 of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239), Congress required the Secretary of Health and Human Services to conduct this study of the IMD exclusion. The study reviews the Health Care Financing Administration's (HCFA) implementation of the policy (Chapter II), and discusses related policy issues (Chapter III). It examines the changes that have occurred in alcohol, drug abuse, and mental health (ADM) services since 1972 (Chapter IV), and reviews the research literature on the cost-effectiveness of ADM services (Chapter V). It also describes the relationship of Medicaid to the support of such care (Chapter VI) and estimates the costs of eliminating the exclusion (Chapter VII). Finally, it discusses relevant policy issues and presents associated actions and recommendations (Chapter VIII).

Major Study Findings

History of the Policy

The basis for the IMD exclusion was established in the 1950 amendments to the Social Security Act. Those amendments excluded assistance payments for IMD patients and those with a diagnosis of psychosis in medical institutions. The creation of the Medicaid program in 1965 and amendments passed in 1972 relaxed the exclusion. They allowed funding for general hospital psychiatric care, inpatient hospital and nursing home care provided to IMD residents age 65 and over, and inpatient psychiatric care for individuals under age 21.

Recent statutory changes have further expanded Medicaid support of inpatient psychiatric care. The Medicare Catastrophic Care Act exempted facilities of 16 beds or less from the IMD designation. This freed States and others to develop small, community-based residential programs without fear of their potential vulnerability to the IMD exclusion. OBRA 90 (P.L. 101-508) permitted the Secretary to allow facilities other than hospitals to qualify as providers of inpatient psychiatric services to persons under age 21.

HCFA emphasizes the overall character of a facility in determining if it might be an IMD. Guidelines include criteria such as whether a majority of the facility's population have mental diseases or whether the facility is under the jurisdiction of the State's mental health (MH) authority. These criteria may be applied to any type of residentially-based program, regardless of licensure, treatment modality, or length of stay of the residents.

In applying the guidelines, HCFA views an entity as a distinct institution if it is separately licensed or certified, and/or separately enrolled as a provider in the Medicare or Medicaid programs. Generally, this means that a psychiatric ward that is part of a general hospital would not be considered an IMD. However, a hospital wing that was separately licensed as a nursing facility (NF) for mental patients would be.

Considerable litigation has challenged HCFA's interpretation and administration of the IMD policy. The most important of these actions culminated in a Supreme Court decision in 1985. The Court found that HCFA's interpretation of the IMD policy was reasonable and did not conflict with Congressional intent. It confirmed that an IMD could be a hospital or nursing home and that the designation could be applied to both public and private facilities.

Although not within the mandated scope of the study, some issues related to the IMD policy were brought to HCFA's attention. One concern is possible mergers between psychiatric hospitals and general hospitals for the purpose of avoiding the IMD designation. Another is the potential effect of HCFA's interpretation of IMD patient status on access to non-ADM medical care. A final one is the possible conflict between current criteria for identifying an IMD and requirements for psychiatric care that NFs now must meet under changes initiated with OBRA 87.

Service System Trends

ADM services can be provided in inpatient or outpatient settings. In addition, partial care settings offer a level of care more intensive than outpatient care, but less than the 24-hour a day services provided in inpatient care. Facilities providing alcohol or drug services are primarily oriented to such treatment, but those providing MH services may also furnish specialized substance abuse care.

For MH inpatient services, the use of State and county mental hospitals has decreased dramatically since 1972, with a drop of two-thirds in beds and annual days of care. In contrast, psychiatric services within general hospitals have increased greatly and now account for more than half of all MH inpatient episodes. Private psychiatric hospitals have experienced the greatest rate of growth, but still only account for about 10 percent of MH inpatient episodes. All MH inpatient facilities increasingly emphasize acute care, but general hospitals have average lengths of stay significantly shorter than others.

The number of annual MH outpatient admissions (additions) doubled from 1971 to 1986. Freestanding outpatient clinics were the major provider of such care in the early 1970's, but by 1986 multiservice MH organizations were the major type of MH outpatient facility. Trends in MH partial care were quite similar to outpatient treatment, with the annual number of people entering partial care more than doubling between 1972 and 1986.

From 1977 to 1989, the rate of inpatient alcoholism treatment decreased, while outpatient and partial care treatment increased by half. All types of drug treatment increased.

The IMD exclusion applies to ADM inpatient facilities. Since the general trend in the total system has been to outpatient or partial care since 1972, this means that the IMD policy now potentially limits Medicaid payment for a smaller proportion of total ADM services. The relatively recent IMD statutory definition that exempts facilities of under 17 beds should further reduce this proportion. It is also likely that the IMD policy affects a smaller proportion of ADM inpatient care than in the early 1970's. The two types of inpatient facilities most clearly meeting the IMD criteria are State and county mental hospitals, and private psychiatric hospitals. From 1972 to the mid-1980's, the proportion of MH inpatient care accounted for by these types of facilities declined by 30 percent.

Cost-Effectiveness Research & Medicaid Support of ADM Services

Research on the treatment of ADM disorders demonstrates that most forms of care produce positive results, and can often justify their expense through reduction of other health care or societal costs. However, they are not equally cost-effective. In the treatment of mental disorders, hospitalization is the most expensive form of care, but not more effective (on average) than alternative, community-based programs. Most assessments of alcohol treatment indicate that outpatient care is as effective as inpatient care, but costs as little as one-tenth as much. Drug treatment studies have not progressed as far. Nevertheless, evidence is consistent with that for alcohol treatment. For all areas of ADM care, most existing research supports the conclusion that the least expensive treatment is the most cost-effective.

Generally, States can use options under Medicaid to support the types of services that have been found to be cost-effective alternatives to traditional psychiatric inpatient care. Outpatient services can be provided as clinic or rehabilitative services, and can include prescription drugs and the services of nonphysician providers (e.g., psychologists). Personal care services and home and community-based waiver services for the mentally ill can be used to provide care to individuals in their homes. Treatment within smaller residential programs in the community can be funded through options such as occupational therapy and rehabilitative services. Finally, to ensure appropriate utilization control and service effectiveness, all types of ADM services can be planned and coordinated through the use of case management.

Medicaid ADM Expenditures and the IMD Exclusion

Recent estimates suggest that Medicaid expenditures for ADM services in 1990 may have exceeded $6 billion, exclusive of long term care. Medicaid expenditures for individuals with ADM disorders in nursing homes may have added more than $2 billion to this figure. The Federal share of even the lowest estimates of Medicaid ADM expenditures exceeds that which was paid under the Alcohol, Drug Abuse, and Mental Health Block Grant in FY 1990.

Eliminating the IMD exclusion would be expensive. Conservative estimates suggest that this statutory change would increase total annual Medicaid expenditures by $3.10 billion, of which $1.73 billion would be the Federal cost and $1.36 billion the State and local cost. Much of these increased expenditures would simply represent a substitution of Federal funding for State and local funding. In the absence of eliminating the exclusion, annual State and local costs for Medicaid eligible individuals in IMDs are estimated to be $2.23 billion. Therefore, State and local governments would experience an estimated $870 million in net annual savings from eliminating the IMD exclusion.

Conclusions

No findings in this study support a recommendation for any statutory change in the IMD exclusion. Court judgments have found that HCFA's implementation of the policy has been reasonable and does not conflict with Congressional intent. Changes that have occurred in ADM services mean that the policy has a smaller impact on the total ADM service system now than it did in 1972. Further, by discouraging the use of psychiatric hospitalization, it appears to be compatible with what is known about cost-effective care. Finally, the majority of increased Federal expenditures that would result from eliminating the IMD exclusion would simply substitute Federal for State and local funding.

Although evidence does not support a statutory change in the IMD policy, the Department is concerned about services for pregnant substance abusers and the lack of information in this area. Accordingly, a new initiative will examine alternative treatment approaches for this group, including IMD services. In September 1991, HCFA selected demonstration projects in five States designed to improve access to treatment for Medicaid-eligible, pregnant substance abusers. The projects are expected to begin in October 1992, and will provide an array of services over a 3-year period.

CHAPTER I

Introduction

Since Medicaid's inception in 1965, medical assistance has been excluded by law for certain patients in institutions for mental diseases (IMDs). As currently defined, an IMD is any facility of more than 16 beds that specializes in psychiatric care. Generally, State mental hospitals, private psychiatric hospitals, and residential substance abuse programs are all examples of IMDs.

Study Mandate

Under section 6408 of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239), Congress required the Secretary to conduct a study of the IMD exclusion. The exact content of the mandate is as follows:

> "(a) Institutions for Mental Diseases. -
>
> (1) Study. - The Secretary of Health and Human Services shall conduct a study of -
>
> (A) the implementation, under current provisions, regulations, guidelines, and regulatory practices under title XIX of the Social Security Act, of the exclusion of coverage of services to certain individuals residing in institutions for mental diseases, and
>
> (B) the costs and benefits of providing services under title XIX of the Social Security Act in public subacute psychiatric facilities which provide services to psychiatric patients who would otherwise require acute hospitalization.
>
> (2) Report. - By not later than October 1, 1990, the Secretary shall submit a report to Congress on the study and shall include in the report recommendations respecting -
>
> (A) modifications in such provisions, regulations, guidelines, and practices, if any, that may be appropriate to accommodate changes that may have occurred since 1972 in the delivery of psychiatric and other mental health services on an inpatient basis to such individuals, and
>
> (B) the continued coverage of services provided in subacute psychiatric facilities under title XIX of the Social Security Act.

(3) Moratorium on treatment of certain facilities. - Any determination by the Secretary that Kent Community Hospital Complex in Michigan or Saginaw Community Hospital in Michigan is an institution for mental diseases, for purposes of title XIX of the Social Security Act shall not take effect until 180 days after the date the Congress receives the report required under paragraph (2)."

In planning the study, it was determined that the short time allowed for its completion prohibited the collection of new data about services or expenditures. No visits were made to individual States or treatment programs. Instead, efforts focused on assembling existing research or statistics that bore on the study's goals.

Another consideration was the references to "subacute psychiatric facilities" in the study mandate. This term does not exist in Medicaid law nor was it defined in the legislation mandating the report. It is generally unknown to mental health (MH) policy researchers and to those who collect data on psychiatric facilities. Rather than attempt a definition of the term in this study, it was decided not to limit it to any particular facility type. Accordingly, the chapter on service system trends and the one on cost-effectiveness present what is currently known about all types of alcohol, drug abuse, and mental health (ADM) services, regardless of treatment setting or length of stay.

Criticisms of the IMD Exclusion

Since the IMD exclusion prohibits Federal Medicaid matching funds (FFP) in certain situations, it is not surprising that it has been criticized. The criticisms vary, but the following paraphrase the most frequent ones:

> The policy is inequitable, and discriminates against those with mental illness. Federal support of Medicaid services should not depend on an individual's residence. Other groups, such as those with developmental disabilities, are not subject to restrictions on Medicaid support of institutional care.
>
> In promulgating the policy, Congress meant to prohibit payment only for services that were custodial in nature and/or provided within traditional State institutions. Since States now emphasize short term and community-based care, the policy now works in a way that Congress never envisioned.
>
> The policy limits Medicaid funding of needed care (e.g., residential treatment of cocaine abusers).
>
> The interpretation of the IMD policy by the Health Care Financing Administration (HCFA) is flawed. It does not reflect Congressional intent and results in some facilities being identified as IMDs that should not be.

OBRA 87 (P.L. 100-203) and the associated requirements for preadmission screening for nursing facilities (PASARR) have created a conflict with the IMD policy. When necessary, OBRA 87 legitimizes the admission of individuals with mental illness to nursing facilities (NFs). It also requires the facilities to provide necessary psychiatric care. This places NFs at risk of being declared to be IMDs and therefore losing Medicaid funding.

Report Content

This report does not address the first criticism that the IMD exclusion is inequitable or discriminatory. Any response to such a charge must be based on political and value judgments about public policy toward ADM services and the relative responsibilities of Federal, State, and local government in supporting such care. However, the report does provide information and data that either directly address the remaining criticisms or assist in their evaluation.

In the chapters that follow, the history of the IMD policy is described (Chapter II) and related policy issues are discussed (Chapter III). Available data on ADM service system trends since 1972 are presented and summarized (Chapter IV). Research on the cost-effectiveness of ADM services is reviewed and discussed in light of the IMD exclusion and related policies (Chapter V). Options available for States within the Medicaid program for expanding ADM care are identified (Chapter VI). Finally, cost estimates are presented of eliminating the IMD exclusion (Chapter VII), along with discussion and conclusions (Chapter VIII).

CHAPTER II

History of the IMD Policy

The Medicaid statute, title XIX of the Social Security Act (the Act), allows States the option of providing inpatient hospital services and nursing facility (NF) services for individuals 65 years of age or over in an IMD, and inpatient psychiatric hospital services for individuals under age 21 [sections 1902(a)(10) and (a)(16); 1905(h)]. The statute further provides that, except for individuals under age 21 receiving inpatient psychiatric care, Medicaid does not cover services to IMD patients under 65 years of age [section 1905(a)(24)(B)].

Medicaid eligibility is not lost for recipients in the excluded age group who are patients in an IMD. Rather, FFP is simply not available for services to such patients. This prohibition reflects the financial nature of the exclusion.

An institution may be designated as an IMD in two major ways. First, a State may identify an institutional provider as an IMD for purposes of offering one or more of the optional Medicaid IMD services (e.g., NF services in a State mental hospital). Second, a participating provider not so identified by the State may nevertheless be determined to be an IMD. Such a determination may result in the provider's withdrawal from the Medicaid program and a disallowance to the State of FFP inappropriately paid for the provider's services. Various reviews to determine providers' possible IMD status have been conducted by HCFA, the Department of Health and Human Services (DHHS), and the Office of the Inspector General (OIG).

This chapter is divided into four sections: the legislative history of the IMD policy, the history of the agency's implementation of the policy, judicial opinions, and a summary. The legislative history shows that Congress has regarded the funding of inpatient treatment of mental disorders to be the primary responsibility of the States, and has maintained this policy for more than 40 years. The description of the agency's implementation of the IMD policy presents the criteria that have been used to identify facilities as IMDs. These have been applied without regard to licensure status and have emphasized the overall character of the facility. The outline of key judicial opinions demonstrates that HCFA's interpretation of the legislation has been found to be reasonable and consistent with Congressional intent.

Although these topics are presented in separate sections, the events described in each did not occur independently. To help clarify the interaction among them, a chronology of major events is provided in Appendix A.

A. Legislative History

The basis for the prohibition of Medicaid payment for IMD patients was established well before the creation of the Medicaid program. The 1950 amendments to the Act (P.L. 81-734) provided that "old age assistance" included payments to those residing in most public medical institutions. However, it specifically excluded assistance to IMD patients or patients being treated for psychosis in other types of medical institutions. Further, House Report No. 1300 noted that the relevant committee did not advocate "Federal participation in assistance to persons residing in public or private [IMDs] . . . since the States have generally provided for medical care of such cases."

Medicaid Legislation

The exclusion of payment for all IMD residents continued until the creation of the Medicaid program in 1965 (P.L. 89-97). For the first time, Congress provided for medical assistance for individuals 65 years or older in IMDs. In addition, prohibitions were removed on funding for the mentally ill in general hospitals. Availability of FFP to States for the elderly in IMDs was contingent, however, on the State making "arrangements for joint planning and for development of alternate methods of care, [and] arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care [section 1902(a)(20)(A)]." A State was also required to show that it was "making satisfactory progress toward developing and implementing a comprehensive MH program, including provision for utilization of community health centers, NFs, and other alternatives to care in public [IMDs] [section 1902(a)(21)]."

The accompanying Report of the Senate Committee on Finance noted that the committee was "particularly concerned that the patient receive care and treatment designed to meet his particular needs. Thus, . . . the State plan would also need to assure that the medical care needed by the patient will be provided him and that other needs considered essential will be met and that there will be periodic redetermination of the need for the individual to be in the hospital [S. Rep. No. 404]."

There is little question that Congress favored and encouraged the transfer of elderly patients from hospitals to less restrictive facilities. However, the Committee also reiterated that "responsibility for the treatment of persons in mental hospitals--whether or not they be assistance recipients--is that of the MH agency of the State." In addition, the House Report on the 1965 amendments explained that the IMD exclusion related to patients in public or private mental hospitals because "long-term care in such hospitals had generally been accepted as a responsibility of the States [H.R. Rep. No. 213]."

States have contended that the references to "mental hospitals" and "long-term care" mean that the IMD exclusion was intended by Congress to apply only to "traditional" mental hospitals, or to services of a custodial nature. These arguments have been examined and addressed in several judicial decisions. They are discussed in detail in section C of this chapter.

1971 and 1972 Medicaid Amendments

In 1971, Congress expanded Medicaid to include coverage of services in Intermediate Care Facilities (ICFs) (P.L. 92-223). In 1972, optional coverage of inpatient psychiatric hospital services for individuals under 21 was added, along with ICF services for the elderly in IMDs (P.L. 92-603). The Conference Report explained that "when a State chooses to cover individuals age 65 and over in [IMDs] it must cover such care in [ICFs] as well as in hospitals and skilled nursing facilities [H.R. Conf. Rep. No. 1065]." The Senate Finance Committee proposed an evaluation of the "potential economic and social benefits of extending medicaid inpatient hospital coverage to mentally ill persons between the ages of 21 and 65 [S. Rep. No. 1230]." However, the proposal was dropped in conference [H.R. Rep. No. 65].

MCCA(88) and OBRA 90

From 1972 until 1988, the statutory text regarding the various IMD coverage options available to States remained essentially unchanged. (Some redesignation of subparagraphs occurred. The term "institution for tuberculosis" was deleted, and "nursing facility (NF)" replaced the terms "intermediate care facility" and "skilled nursing facility.") Congress did not define the term "IMD" until passage of the Medicare Catastrophic Care Act (MCCA) of 1988 (P.L. 100-360), when section 1905(i) was added to the Act: "The term 'IMD' means a hospital, NF, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."

This section incorporated most of HCFA's longstanding regulatory definition into the statute. The one notable change was the requirement for a facility to have more than 16 beds before it is an IMD. This change allowed States to develop group homes and other small, community-based residential programs without fear of their potential vulnerability to the IMD exclusion.

In OBRA 90 (P.L. 101-508), Congress provided authority for the Secretary to expand coverage of inpatient psychiatric hospital services for individuals under age 21. HCFA is developing regulations that will allow additional inpatient settings to qualify as providers of this service. It will also establish standards for such providers.

B. History of Agency Actions

The first issuance dealing with the IMD exclusion was published in 1966 in the Handbook of Public Assistance Administration, Supplement D, Medical Assistance Programs (HPA). The HPA provided that FFP could not be claimed in medical assistance for: "Any individual who has not attained 65 years of age and is a patient in an [IMD]; i.e., an institution whose overall character is that of a facility established and maintained primarily for the care and treatment of individuals with . . . mental diseases (whether or not it is licensed) [HPA, D-4620.2]."

Regulations

Formal regulations establishing the IMD exclusion were published June 24, 1969, as 45 CFR 249.10. The regulations addressed the amount, duration, and scope of medical assistance, and specifically excluded FFP for services provided to IMD patients less than 65 years of age.

On February 27, 1971, the HPA provisions concerning the overall character of an IMD were incorporated into regulations (45 CFR 248.60, later redesignated as 42 CFR 435.1009). This section also contained the following definitions:

> "(1) 'Institution' means an establishment which furnishes (in single or multiple facilities) food and shelter to four or more persons unrelated to the proprietor, and in addition, provides some treatment or services which meet some need beyond the provision of food and shelter."
>
> "(7) 'IMD' means an institution which is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services."

The current regulations defining "IMD" and establishing the IMD exclusion are essentially identical to these, with the exception that they now incorporate the MCCA provision that an IMD be larger than 16 beds. They state that an IMD is determined by its overall character, and does not depend on its licensure. They also clarify that an institution for the mentally retarded is not an IMD (42 CFR 435.1008, 435.1009, and 441.13).

Field Staff Instructions

The Federal agency which first administered the Medicaid program was the Social and Rehabilitation Service (SRS) of the Department of Health, Education, and Welfare. In 1978, Medicaid components of SRS were merged with Medicare components of the Social Security Administration to form HCFA, the Federal agency that now administers the two programs.

Operational policy for determining if a facility is an IMD was first set forth by SRS in Field Staff Information and Instruction Series (FSIIS) issuance FY-76-44, dated November 7, 1975. The issuance stated that:

> "The character rather than the licensure status of the institution is of paramount importance. The excluded institutions are those 'primarily' providing care for patients with 'mental diseases.' An institution is characterized as 'primarily' one for mental diseases if it is licensed as such, if it advertises as such or if more than 50 percent of the patients are in fact patients with mental disease. In some instances a facility may be 'primarily' concerned with such individuals because they concentrate on managing patients with behavior or functional disorders and are used largely as an alternative care facility for mental hospitals, even if less than 50 percent of the patients have actually been diagnosed as having a mental disease. Mental diseases are those listed under the heading of mental disorders in the eighth revision, International Classification of Diseases, Adapted for Use in the United States (ICDA-8 . . .), except that mental retardation is not included for this purpose. The underlying cause of the mental disease is irrelevant. Although many individuals suffer from a combination of mental and physical disorders there is usually no problem in discerning which is responsible for the need for institutional care."

FSIIS FY-76-44 further instructed the SRS regions to concentrate on skilled nursing facilities (SNFs) and intermediate care facilities (ICFs) in determining whether a problem existed with improper claims from IMDs.

In 1976, a second FSIIS issuance (FY-76-97) emphasized that the policy regarding FFP for persons in IMDs was not new and that SNFs or ICFs could be IMDs. The transmittal also reiterated the importance of regional monitoring of State claims for FFP for recipients in suspected IMDs.

Another issuance in 1976 (FY-76-156) expanded the criteria used to evaluate a facility's possible IMD status. The additional criteria were: proximity to State institutions, an age distribution uncharacteristic of nursing home patients, and whether the "basis of Medicaid eligibility of patients under 65 in suspect facilities was due to mental disability." More importantly, it established the methodology to be used in classifying patients under the "50 percent" criterion:

> "[A review team should be used] to review patients in those facilities where the determination cannot be made without applying the 50 percent criterion. The team would make a judgment about each patient as to the presence or absence of disability in functioning resulting from a mental disease and whether the mental disability resulted in the patient's need for skilled nursing or intermediate care. Patients would be classified as follows:

a. Patient with physical problem necessitating nursing home care who has no mental disability;

b. Patient with mental disability and physical problem, either of which would independently require nursing home care;

c. Patient with mental disability necessitating nursing home care who has no significant physical problem; and

d. Patient with physical problem that would not independently necessitate nursing home care, but who has a mental disability that would preclude his proper handling of his physical problem outside a nursing home. Therefore, nursing home care is necessitated because of his mental disability in functioning.

Patient categories c and d are designated as mental patients for purposes of this determination, and should be included in the mental patient census."

State Medicaid Manual

The State Medicaid Manual (SMM) is provided to all State Medicaid agencies and provides technical information and clarification of Medicaid policy. In 1982, HCFA incorporated into the SMM the IMD criteria established in the FSIIS issuances. The transmittal notice stated that the new SMM section 4390 "consolidates and clarifies the previous instructions and makes them obsolete." The issuance listed 10 guidelines to be used cumulatively to determine a facility's overall character:

"1. The facility is licensed as a psychiatric facility for the care and treatment of individuals with mental diseases;

2. The facility advertises or holds itself out as a facility for the care and treatment of individuals with mental diseases;

3. The facility is accredited as a psychiatric facility by the JCAH;

4. The facility specializes in providing psychiatric care and treatment. This may be ascertained through review of patients' records and may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric training;

5. The facility is under the jurisdiction of the State's MH authority;

6. More than 50 percent of the patients have mental diseases which require inpatient treatment according to the patients' medical records;

7. A large proportion of the patients in the facility has been transferred from a State mental institution for continuing treatment of their mental disorders;

8. Independent Professional Review teams report a preponderance of mental illness in the diagnoses of the patients in the facility (42 CFR 456.1);

9. The average age in the facility is significantly lower than that of a typical nursing home;

10. Part or all of the facility consists of locked wards."

In addition, for the purposes of "patient-counting" under Guideline No. 6 (the "50 percent" criterion), diagnoses relating to senility were excluded from consideration as mental diseases. The transmittal also emphasized that if it was not clear that institutional care resulted from a mental disability, "the patient should not be included in the mentally ill category."

In 1986, HCFA revised section 4390 to provide "additional information relating to organic brain syndrome, facilities that specialize in treatment for alcoholism and drug addiction, and facility review methodology." Guideline No. 4 was expanded to read:

"4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or by the fact that a large proportion of the patients are receiving psychopharmacological drugs."

The revision also clarified that organic brain syndrome (dementia) was included with senility as a diagnosis exempt from the 50 percent rule. It noted that "[i]f the facility is treating these patients for the effects of a mental disorder . . . , other guidelines . . . should result in a determination that the facility is an IMD." In applying Guideline Nos. 4 and 6, it also recommended the inclusion on the review team of at least one physician or other person familiar with the care of mentally ill persons.

Most significantly, the SMM 4390 revision included a clarification required by a Departmental Appeals Board (DAB) decision regarding the way in which alcoholism treatment facilities are reviewed (see section C). The clarification adopted the Board's reasoning that there is a "continuum of care for alcoholism." At one end of this spectrum of care, treatment follows a psychiatric model and is performed by medically-trained personnel. At the other end of the spectrum of care, treatment focuses on peer counseling and self-help, and follows the Alcoholics Anonymous model.

The SMM 4390 clarification notes that:

> "The major factor differentiating these [self-help oriented] facilities from other alcoholism treatment facilities is the reliance on lay versus medical staff. Lay counseling (as the primary method of care) does not constitute 'medical or remedial treatment' required for Medicaid reimbursement under 42 CFR 440.2(b). Moreover, the regulation defining an IMD (see 42 CFR 435.1009) requires 'medical attention, nursing care and related services' to treat mental diseases and does not encompass facilities providing essentially lay services. Since payment for lay services (except as an adjunct to medical care of a physical or mental condition) is not available under Medicaid and since IMDs by regulation are providing 'medical attention,' do not count patients admitted to a facility only for lay counseling or Alcoholics Anonymous-type social services for alcoholism as mentally ill under Guideline 6. Federal matching funds may not be claimed for care in a hospital, SNF, or ICF when such treatment is the sole reason for the inpatient stay. Facilities may not, however, avoid having their alcoholic patients counted as mentally ill under Guideline 6 by withholding appropriate treatment from those patients; facilities failing to provide appropriate treatment to patients risk termination from the program.
>
> When facilities provide alcoholism treatment under the direction of a medical staff, this is considered 'medical attention.' If medical services are psychological or psycho-social in nature and are designed to alter the patient's maladaptive drinking behavior, the services are considered medical treatment of a mental disease and alcoholic patients admitted for such treatment are to be counted as mentally ill under Guideline 6. The psychological or psycho-social services provided do not have to be intensive or restrictive in nature in order for such patients to be counted as mentally ill. Facilities may not claim Medicaid reimbursement for providing nursing facility or hospital services to patients admitted for treatment of alcoholism and simultaneously claim that they are providing only social services to those same patients for purposes of applying Guideline 6."

C. Judicial Decisions

The intent and scope of the "IMD exclusion" have been sources of controversy between the States and the Federal government, involving many administrative appeals and several court actions. Since 1981 there have been eight DAB decisions dealing with IMD identification. In addition, there have been six District Court decisions, six Appeals Court decisions, and a Supreme Court decision addressing the IMD exclusion. Since 1987, the Office of the Inspector General (OIG) has been conducting reviews of suspected IMDs on a nationwide basis, using guidelines that have emerged from litigation.

The following discussion describes key DAB and court decisions in this area. Another issue has been regulations that allowed FFP for "partial months of eligibility" (PMEs) for IMD patients. This issue is presented in Appendix B.

Supreme Court Decision

From 1978 through 1980, HCFA and the OIG conducted a series of reviews of suspected IMDs in a number of States. As a result of these reviews, HCFA disallowed FFP for services in certain SNFs and ICFs in four States: Connecticut, Minnesota, Illinois, and California. The States jointly appealed the disallowances to the DAB.

In their arguments to the DAB, the States contended that Congress intended the IMD designation to only apply to mental hospitals that traditionally cared for the mentally ill. Under this interpretation, the exclusion would apply to SNF or ICF services only when provided in a State mental hospital. The States' rationale was that the references to "mental hospitals" in the legislative history meant that SNFs and ICFs were intended by Congress to be alternatives to care in traditional mental institutions. The States also noted Congress' clear endorsement of the development of alternatives to "traditional" care.

The States further argued that HCFA's interpretation of the IMD exclusion was inconsistent with statutory and regulatory prohibitions against discrimination on the basis of diagnosis. Lastly, the States attacked HCFA's use of the criteria for evaluating whether facilities were IMDs. They charged that the criteria were "impermissibly vague" and asserted that the 50-percent rule in particular was arbitrary, invidious, and resulted in the diagnostic labeling of patients.
HCFA argued that its interpretation was supported by the statute. Further, it contended that the criteria were used only to gather information concerning the overall character of the facility under review. Finally, it claimed that the States' interpretation of the statute would render the IMD exclusion essentially meaningless.

In 1981, the DAB upheld each of the disallowances in full [Decision No. 231]. (A DAB decision represents the final decision of the Secretary of Health and Human Services in such disputes.) Each State sought court review of the Board's decision.

Connecticut's case was eventually heard by the Supreme Court [State of Connecticut Dept. of Income Maintenance v. Heckler, 471 U.S. 524 (1985)]. The Court unanimously affirmed the decision of the Court of Appeals for the Second Circuit that had supported the DAB decision. Pertinent points in the Supreme Court decision include the following:

- The applicable statutory language "plainly indicates that a hospital, an SNF, or an ICF may be an IMD." Further, the Court judged that the Report of the Senate Committee on Finance (S. Rep. No. 404) "made it clear that the IMD exclusion applie(s) to both public and private mental institutions."

- HCFA's interpretation of what constitutes an IMD "comports with the plain language of the statute . . . " and " . . . the legislative history does not reveal any clear expression of contrary congressional intent."

- The one ICF in the case was found to be an IMD. The Court found that the facility was "primarily engaged" in providing treatment and care for persons with mental diseases. The Court's finding was based on "ample evidence" contained in the record including such factors as the percentage of patients having a major mental illness, the number of transferees from State mental hospitals, the specialization of the facility's staff in caring for the mentally ill, and the fact that the facility held itself out as specializing in the treatment of mental diseases.

Classification of Alcohol and Drug Treatment Centers

In 1980, Granville House, Inc., the operator of three residential chemical dependency centers in Minnesota, challenged the Secretary's classification of alcoholism and chemical dependency as mental diseases. In 1982, the District Court of Minnesota found that the Secretary's "classification of alcoholism and other forms of chemical dependency as mental disorders is unreasonable and, therefore, the . . . characterization of [these] facilities as [IMDs] is arbitrary and capricious [Granville House v. Dept. of HHS, No. 4-80-279]." On appeal, the Court of Appeals for the Eighth Circuit ordered that the case be remanded to the DAB to decide "whether alcoholism and chemical dependency, both of which are classified as mental diseases in the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM), are properly characterized as mental diseases" for the purpose of identifying facilities as IMDs [No. 84-5195].

In 1984, the DAB concluded that "HCFA may not reasonably categorize Granville's facilities as IMDs based merely on the predominance in those institutions of persons diagnosed and treated for alcoholism. Given the uniqueness and complexity of the disease and its treatment, we conclude that HCFA may determine IMD status for an institution treating alcoholism only on the basis of more definitive rules or guidelines which enable HCFA and its constituents to better evaluate what types of alcoholism treatment are, and are not, conclusive of IMD status [Decision No. 529]."

The guidelines required by the Board were issued by HCFA as part of the 1986 revision to SMM section 4390 (see discussion under section B). Using the revised guidelines, Minnesota disallowed reimbursement to Granville House for alcoholic and other chemically dependent residents age 21 to 64 at two of the firm's ICFs. Granville House appealed the State disallowance to the DAB. The DAB ruled that Minnesota had correctly determined that the ICFs were IMDs (Decision No. 912). Among the evidence persuading the DAB was the certification of the ICFs as psychiatric facilities by the JCAH, and documentation submitted by Granville House representing the ICFs as inpatient psychiatric facilities.

Nature of the IMD Exclusion

A final key decision by the DAB confirmed that the IMD exclusion represents a limit on payment for services, rather than a restriction on provider participation. It also clarified that the exclusion is not limited to long-term care (LTC), and applies regardless of the duration of treatment. In 1988, Pennsylvania made several large claims for services for individuals between 22 and 65 years of age in IMDs. HCFA disallowed the claims and Pennsylvania appealed to the DAB.

The State contended that the claims were for inpatient "emergency hospital services" as described at 42 CFR 440.170(e). That regulation, the State argued, "created an exception to the IMD exclusion, authorizing FFP in all emergency hospital services by waiving requirements which normally apply to inpatient hospital services, including the requirement that the hospital not be an IMD." Pennsylvania also cited a reference to "long-term care" in the Supreme Court Connecticut decision to argue that Congress intended that the IMD exclusion apply only to patients receiving LTC services.

The DAB upheld the disallowances, finding that the emergency hospital regulation does not waive the IMD exclusion (Decision No. 1042). The Board noted that section 440.170(e) "does not waive limits on services; the wording of the regulation indicates that it waives only the conditions a hospital ordinarily must meet to qualify as a Medicaid provider [emphasis in original]."

The DAB also addressed Pennsylvania's reliance on the references to "long-term care" in the Supreme Court decision and the legislative history of the IMD exclusion:

> "This reliance is misplaced because it ignores the wording of the statute itself which excludes care or services for any individual in an IMD irrespective of the duration of the care. Moreover, Congress specifically applied the exclusion not only to nursing facilities (which are normally identified with 'long-term care'), but to inpatient hospital services, which would include acute care on a short-term basis."

D. Summary

Since the beginning of the Medicaid program, Federal matching funds have been excluded for services provided to certain IMD patients. The basis for this prohibition was established in the 1950 amendments to the Social Security Act, well before Medicaid's creation in 1965. Provisions in the original Medicaid program and amendments passed in 1972 relaxed the exclusion. They allowed funding for general hospital psychiatric care, inpatient hospital and nursing home care provided to IMD residents 65 and over, and inpatient psychiatric care for individuals under 21.

Recent changes in Medicaid law have further relaxed restrictions on Medicaid support of inpatient psychiatric care. MCCA incorporated the definition of an IMD that already existed in Medicaid regulations, with the exception that facilities of 16 beds or less were exempted from the designation. This freed States to develop small, community-based residential programs without fear of their potential vulnerability to the exclusion. OBRA 90 allowed further expansion of inpatient psychiatric services to persons under 21.

In developing associated policy, HCFA has emphasized the overall character of a facility in determining if it might be an IMD. Guidelines include criteria such as whether a majority of the facility's population have mental diseases or whether the facility is under the jurisdiction of the State's MH authority. These criteria may be applied to any type of residentially-based program of more than 16 beds, regardless of licensure, treatment modality, or length of stay of the residents. Thus, a hospital, nursing home, or freestanding residential treatment center could be an IMD if it were primarily engaged in providing services to persons with mental diseases.

Considerable litigation has challenged HCFA's interpretation and administration of the IMD policy. The most important of these actions culminated in a Supreme Court decision in 1985. The Court found that HCFA's interpretation of the IMD policy was reasonable and did not conflict with Congressional intent. It confirmed that an IMD could be a hospital or nursing home. It also stated that the designation could be applied to both public and private facilities. Other judgments have determined that a facility's IMD status should not be based on a single criterion. Additionally, the exclusion represents a limit on payment for services, rather than a restriction on provider participation, and applies regardless of the duration of treatment.

CHAPTER III

Related Issues

Several other issues have been raised regarding IMD-related policies or associated agency practices. The first of these pertains to the definition of an "institution" for purposes of applying the IMD criteria. The second concerns the interpretation of Medicaid eligibility for IMD patients. The third involves the relationship of the IMD exclusion to recently enacted requirements for screening of individuals with mental illness seeking admission to a nursing facility.

A. Definition of an "Institution"

In recent months, HCFA has become aware of a few cases in which it appeared that mergers of psychiatric hospitals with general hospitals were planned or made for the purpose of avoiding the IMD exclusion (e.g., Pitz, 1991). These mergers may have been permitted by the rules that the agency currently uses to identify an "institution." In most cases, it is not difficult to identify an institutional entity for purposes of determining whether it is an IMD. However, some combinations of providers may make the identification of the "institution" in question more complicated. In these cases, it is necessary to isolate the "institution" before applying the IMD guidelines.

Generally, HCFA considers an entity to be a distinct institution on the basis of its licensure and/or its certification as a provider in the Medicare or Medicaid program. In determining whether components of a medical complex or organization are independent or not, HCFA relies on the guidelines in sections 2024 and 2026 of the State Operations Manual. The components are considered to be part of a single institution if:

1. they are subject to the control and direction of a single owner;

2. there is one chief medical officer who is responsible for all medical staff activities in all components;

3. the medical staff of all components are integrated; and,

4. there is a single chief executive officer who exercises control over the administrative activities of all components.

If an institution meets these criteria, it is considered a single institution, except for components that are separately licensed or certified as other types of providers.

In most cases, application of these guidelines results in a general hospital psychiatric ward being considered a component of the hospital rather than an independent institution (and an IMD). Such a ward is not subject to the IMD exclusion unless it is so large that it results in the overall character of the hospital being that of an IMD.

B. Eligibility and Payment

The OIG identified what it considered to be an inconsistency in the Medicaid statute between the provisions on eligibility and the IMD exclusion. Among other eligibility provisions, section 1902(a)(10) requires recipients of Supplemental Security Income (SSI) cash benefits to be made eligible for Medicaid. The IMD exclusion, on the other hand, precludes medical assistance for IMD patients under age 65, even though they may be Medicaid eligible.

Generally there is a direct correlation in the Medicaid program between the determination of an individual's eligibility for medical assistance and the provision of medical assistance to the eligible individual. Because this correlation does not hold for individuals under age 65 in IMDs, it may appear that an anomaly exists. In effect, these individuals have been determined to be eligible for Medicaid, but because they are in IMDs, medical assistance is not available to them.

The apparent contradiction of individuals in IMDs who are eligible for Medicaid but cannot get medical assistance arises from confusion resulting from two common usages of the term "eligibility." In one context, "eligibility" refers to groups of individuals and associated criteria for determining who can receive Medicaid. In the other context, "eligibility" refers to the services the eligible individuals can receive; i.e., what constitutes medical assistance.

Section 1902(a)(10) includes eligibility provisions related to the first context, that is, which define the groups that can get Medicaid. That section alludes to the second context by referring to section 1905(a), which identifies the services that can be provided by medical assistance. Section 1905(a) specifically excludes payment for services furnished to individuals under age 65 who are in IMDs from the definition of medical assistance.

Thus, it is only an apparent inconsistency that was identified by OIG. This "inconsistency" is resolved with the recognition that the Medicaid statute includes two provisions which are distinct and, with respect to IMDs, separate. Therefore, it is possible for an individual to be a member of an eligible group, but still not be able to receive medical assistance. This occurs when SSI payments are made to individuals who are under age 65 and in an IMD. Although such individuals are technically eligible (i.e., members of an eligibility group), no medical assistance is available. However, their Medicaid eligibility allows them to receive applicable administrative services (e.g., case management) and they may receive medical assistance upon discharge without having to apply for the program.

A related issue concerns the application of the IMD exclusion in situations involving temporary absences from an IMD. Regulations implementing the IMD exclusion specify that individuals who are on "conditional release" or "convalescent leave" from an IMD would not be considered patients in an IMD and medical assistance would be available during the leave period (42 CFR 435.1008). SMM instructions explain that convalescent leave and conditional release relate to the course of treatment of individuals' mental disorders. If a patient is sent home for a trial visit, this is convalescent leave. If a patient is released from an IMD on condition that he or she receive outpatient treatment or on other comparable conditions, the patient is on conditional release.

If a patient is temporarily released from an IMD for the purpose of obtaining medical treatment (e.g., surgery in a general hospital), this is not considered to be either of these categories of release and the patient is considered to remain in the IMD. In such a situation, medical assistance is not available during the absence. It has been questioned if this policy limits the availability of critical (non-ADM) medical care for IMD patients or if it provides disincentives for IMDs with limited medical services (e.g., residential treatment centers) to admit Medicaid eligible patients.

C. PASARR

A final issue associated with the IMD policy concerns the provisions in OBRA 87 and 90 related to preadmission screening of NF applicants [section 1919(b)]. These requirements are commonly referred to as PASARR, for "Pre-Admission Screening and Annual Resident Review." Under PASARR, the MH authority in each State must evaluate all individuals with serious mental illness who apply for admission to a Medicaid-certified NF, including facilities that participate in the program as IMDs. The authority must determine if such applicants require NF services. It also must ascertain if they need specialized services for their mental illness.

If admission to an NF is approved and specialized services are required, then the Medicaid agency must see that they are provided. "Specialized services," as characterized by HCFA, would be essentially equivalent to the type and degree of care delivered in an inpatient psychiatric setting, a level of service intensity greater than that ordinarily provided within an NF. These requirements make it unlikely that many mentally ill individuals who require specialized services will actually enter an NF.

However, even if specialized services are not needed, other provisions added to section 1919 by OBRA 87 and 90 increase the responsibilities of NFs for their residents with mental disorders. NFs now must furnish "treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State [section 1919(b)(4)(vii)]." In practice, these and other provisions generally require the NF to provide all necessary psychiatric care of an intensity below the specialized services level. The plan of care must describe a resident's psychosocial needs and the NF must provide services and activities to attain

or maintain the highest practical physical, mental, and psychosocial well-being of the resident.

Critics have contended that, by authorizing the admission of mentally ill (MI) individuals to NFs, PASARR creates a process which could cause NFs to become IMDs, outside of the power of the State Medicaid agency to prevent. As a result, they believe that the enactment of the PASARR requirements represents a de facto modification of the IMD exclusion. In their view, any person with mental illness admitted to an NF through the PASARR process should not be counted in connection with an IMD determination. Additionally, under the enhanced description of NF services, they charge that some of the IMD criteria would inappropriately identify a well-operated NF as an IMD even if less than half of its population had a mental illness.

The agency strongly disagrees with these views. It has always been possible to admit persons with mental illness to NFs and for the overall character of an NF to become that of an IMD. Nothing in the PASARR provisions requires the law to be reinterpreted otherwise. Nevertheless, the Agency does agree that the SMM guidelines, as currently worded, describe characteristics that may be found in NFs that are complying with OBRA 87 and 90 rules. For example, this could happen if an NF has specially trained staff or holds itself out as providing specialized psychiatric services.

Regarding the PASARR process, however, both NFs and State agencies have the means to prevent 50 percent or more of an NF's population being composed of individuals with a mental disorder. A facility that is concerned about its potential IMD status is not obliged to admit an individual with mental illness solely because he/she has been certified for admission. More importantly, the IMD policy implicitly expects that a State will effectively discharge its responsibility to provide sufficient ADM services for its citizens. If it does, adequate numbers of State-supported facilities should exist for those who require residential placement primarily for the treatment of mental illness. Within the PASARR process, the State has the authority to develop preadmission screening criteria that ensure that such individuals are identified and directed to an appropriate (non-NF) setting. From this perspective, the potential for an individual NF to become an IMD serves as an important incentive for States to fund an appropriate level of alternative services.

D. Summary

Other issues related to the IMD policy have been raised. Although not directly related to the legislative mandate of this study, they have been included to add to an understanding of this area. One concern is possible mergers between psychiatric hospitals and general hospitals for the purpose of avoiding the IMD designation. These may be permitted under current agency guidelines for identifying an "institution." Another is the potential consequences of the agency's interpretation of IMD patient status on access to non-ADM medical care. A final one is the apparent effect of OBRA 87 nursing home reforms on the likelihood of NFs being designated as IMDs.

CHAPTER IV

Trends in the ADM Service System

This chapter examines the ADM service system and how it has changed since 1972. In the sections to follow, trends in the organized MH service system are described. This system incorporates a continuum of care ranging from inpatient and residential treatment (24-hour care), through partial (3-23 hour per day/night) to outpatient (clinic) care. Changes from 1972-1985 in specific facility types are then presented. Next, trends in facilities providing services for chemical dependency are shown. Finally, changes in nursing home care are reviewed, and trends in the complete ADM service system summarized.

Since 1972 the rate of annual additions to MH inpatient facilities has changed little, while rates for outpatient and partial care services have increased significantly. Of the types of facilities providing inpatient care, State and county mental hospitals, and private psychiatric hospitals are generally the ones most affected by the IMD exclusion. These two types of facilities account for a smaller proportion of total psychiatric inpatient care in the mid-1980's than they did in 1972. Although both have reduced their average lengths of stay since 1972, these stays still are 2 to 10 times longer than those of inpatient psychiatric settings that are generally coverable under Medicaid (e.g., general hospital psychiatric wards).

Information concerning facilities for alcohol and drug treatment is less complete than that for MH services. Nevertheless, it appears that for alcohol treatment, inpatient or residentially-based treatment has decreased, while outpatient and other ambulatory services have increased. All types of drug treatment have increased. Within nursing homes, the proportion of the resident population with ADM disorders other than dementia has remained relatively stable since the early 1970's.

Data and Terminology

Data for this chapter were drawn from several sources. These include surveys conducted by the National Institute of Mental Health (NIMH), the National Drug and Alcoholism Treatment Unit Survey (NDATUS), the National Center for Health Statistics' Hospital Discharge Survey (HDS), and the American Hospital Association's (AHA) Hospital Statistics. These sources overlap to some degree, and do not always use similar methodologies or terminologies. Limitations of each of these sources, and the methods used for integrating them are described in Appendix C.

Within this chapter and the remainder of the report, the term "residents" refers to patients in a treatment facility on a given day. "Episodes" refers to the number of patients being treated at the beginning of the year plus additions during the year. "Additions" refer to new admissions plus readmissions. For inpatients, "additions" may

also include persons who have returned from long term leave or transferred from noninpatient settings.

Several terms describe diagnoses. "ADM" refers to the total aggregate of alcohol, drug, or mental disorders, or to services for such. For purposes of this report, "mental disorders" is used to refer to the subset of diagnoses that exclude alcohol or drug disorders. "MH" refers to services or facilities primarily for the treatment of mental disorders. The term "psychiatric" is used when data are unclear as to whether all ADM or only mental disorders are included. "Chemical dependency" refers to either alcohol or drug disorders to the exclusion of all other psychiatric disorders while "alcohol" or "drug disorders" refer to the named disorder/condition to the exclusion of all other disorders. Other specialized terms used in this chapter are included in the Glossary.

A. MH Service System

The MH service system outlined here is defined primarily by data published by NIMH in the Mental Health United States series. These reports represent the most complete data available on the organized MH service system. The facilities include all non-Federal and Veterans Administration (VA) general hospitals identified as having separate psychiatric services; State, county, and private psychiatric hospitals; VA neuropsychiatric hospitals; psychiatric outpatient clinics; psychiatric day/night organizations, and multiservice mental health organizations not elsewhere classified. Until 1981, Community Mental Health Centers (CMHCs) were also included in these data. At that time, when CMHC funding was changed, the CMHCs were reclassified into either general hospital psychiatric services, freestanding outpatient clinics, or multiservice mental health organizations.

Specialized alcohol and/or drug service facilities that are not included in the facilities reported by NIMH are not included in this section, but described later in the section on chemical dependency. In addition to medical facilities, these facilities include those that focus on nonmedical alcohol and/or drug treatment. They also include those where the facility is not a medical care provider and not under the control or administration of a medical care provider. Nevertheless, the MH service system also treats alcohol or drug problems, and these are included in the patient data that follow.

MH Inpatient Service System

Inpatient facilities provide ADM services to persons requiring 24-hour supervision. The facilities described in this section include all those with an organized psychiatric unit, although patients treated in the unit may be diagnosed with an alcohol, drug, or mental disorder. Generally, these facilities are hospitals or sections of hospitals, but they may include some Residential Treatment Centers (RTCs) or multiservice MH organizations that are not direct components of hospitals (see Glossary).

MH Inpatient Facilities Table 4.1 shows the number of MH inpatient facilities by type from 1972 to 1986. The total number of such facilities has increased from 1,913 in 1972 to 3,039 in 1986 (59 percent). In 1972, non-Federal general hospital psychiatric units accounted for 34 percent of the MH inpatient facilities. Seventeen percent were State and county mental hospitals, 18 percent were RTCs for children, 15 percent were CMHCs, and 8 percent were private hospitals.

By 1986 State and county mental hospitals had decreased to 9 percent, and private psychiatric hospitals accounted for 10 percent of the total. General hospital units increased to 42 percent, RTCs decreased slightly to 14 percent, CMHCs ceased to exist as such, and "other" (multiservice organizations) increased from 2 percent to 19 percent of total facilities. (Facilities that were classified as CMHCs prior to 1981 were reclassified into multiservice MH organizations, general hospital psychiatric units, or freestanding psychiatric clinics, depending on the services offered by the facility. This accounts for the increase in general hospital units and "all other organizations" between 1980 and 1982.) In addition to the facilities presented in Table 4.1, there are over 4,500 general hospitals without psychiatric units which treat patients with primary ADM diagnoses. These are discussed later in this chapter.

MH Inpatient Beds Table 4.2 shows the number of MH inpatient beds by facility type. Overall, the number of beds devoted to ADM disorders in specialty sites dropped by 200,000 from 1972 to 1986 (a 43 percent decrease). This change resulted from a decrease in State hospital beds from 360,000 in 1972 to 123,000 in 1986 (a 66 percent decrease). This decrease in MH inpatient beds occurred while the number of inpatient facilities was increasing (Table 4.1). Thus, it appears that the closing or downsizing of large State facilities was accompanied by the opening of many smaller (primarily private) ones.

Mental Health Inpatient Episodes and Additions Although a decrease in beds might suggest fewer people served, Table 4.3 shows that total inpatient episodes in MH facilities increased by 328,000 (15 percent) from 1972 to 1986. Table 4.4 illustrates that the rate of total inpatient additions increased modestly (16 percent). Aside from CMHC elimination (as a category), State hospitals are the only site to decrease inpatient episodes in this time period, from 745,000 to 445,000 (40 percent). No apparent trend was evident for VA Medical Centers.

General hospitals account for more than half of the episodes of psychiatric treatment. The number of episodes that occurred in psychiatric units of these hospitals increased more than 50 percent from 1972 to 1986. Private psychiatric hospitals account for less than half of the episodes accounted for by general hospitals, but experienced a large increase in episodes over the period (164 percent).

MH Inpatient Days of Care Table 4.5 shows total days of care by facility type. The system as a whole dramatically decreased from 154 million days of care in 1972 to 83 million in 1986, mostly due to a reduction of 67 percent in days of care in State hospitals.

MH Inpatient Length of Stay Table 4.6 shows that from 1972 to 1986, average length of stay for all facilities has decreased about 50 percent, from 87.5 days to 44 days. These figures underestimate true length of stay, since they do not include the full lengths of stay for long term patients. This is particularly applicable for State and county mental hospitals, which typically serve both long term and acute care patients.

In 1972, 93 percent of all State and county mental hospitals and 53 percent of all private psychiatric hospitals were classified as long-term. By 1986 these percentages had dropped to 87 percent and 39 percent, respectively. Although the three organizations with the longest length of stay in 1972 (RTCs for children, VA Medical Centers, and State hospitals) had the largest decrease, they still had the longest lengths of stay in 1986. General hospitals with and without psychiatric units continued to have lengths of stay significantly shorter than other MH inpatient settings.

MH Outpatient Service System

An outpatient facility provides ambulatory MH services. Most outpatient facilities are associated with a hospital, but many are freestanding psychiatric clinics.

MH Outpatient Facilities Table 4.7 shows that the number of facilities providing outpatient services increased by about 30 percent from 1972 to 1986. In 1972, almost half of the facilities that offered outpatient ADM services were freestanding outpatient clinics. By 1986, this number had dropped to about 26 percent of all facilities providing outpatient ADM treatment. In 1972, the "all other" category of facilities, mostly comprising multiservice MH organizations, accounted for less than 2 percent of total MH outpatient services. However, this increased to 42 percent in 1986.

Changes in classification make it unclear whether changes in particular facility types reflect actual increases or decreases. Many CMHCs were reclassified as multiservice organizations after 1981. In 1984, changes in the definition of multiservice organizations resulted in many outpatient clinics being so classified.

MH Outpatient Additions Table 4.8 shows that outpatient additions approximately doubled from 1971 to 1986. Table 4.9 demonstrates that this change represents a 71 percent increase in the rate of MH outpatient treatment. Contrary to the data presented for inpatient care, these figures do not accurately estimate total MH outpatient utilization. A considerable amount of outpatient treatment takes place in such settings as school systems, prisons, and university counseling centers. In addition, physicians, psychologists, and others in private practice see a very large number of ADM patients.

In 1972, about 10 percent of all outpatient additions were to mental hospital outpatient clinics (State, county, or private). By 1983 this percentage had dropped to about 7 percent. Non-Federal general and VA hospital outpatient clinics accounted for about 24 percent of the outpatient additions in 1972 and 22 percent in 1986. Virtually all of the actual increase in additions was attributable to the "other" category largely

composed of multiservice mental health organizations. Overall, all facility types increased their outpatient case loads, with the exception of the State and county mental hospitals and the reclassified CMHCs.

MH Partial Care Service System

Partial care facilities are those facilities that provide MH services to persons who do not require 24-hour inpatient hospitalization but do require more services/supervision than is provided in outpatient settings. Specifically, partial care is defined as 3-23 hours of care daily. Partial care may be labeled as partial hospitalization, or day or night treatment. Services provided by partial care programs may focus on treatment, education, or support, or some combination of these.

MH Partial Care Facilities In 1972 there were just under 1,000 facilities providing partial care (3-23 hours per day) for ADM disorders. By 1986 this number had almost doubled (see Table 4.10). In this period, the number of facilities providing partial care services decreased for State and county mental hospitals and freestanding psychiatric clinics (and the reclassified CMHCs). They increased for all other facility types, with the major increase in the "all other" facility category consisting mostly of multiservice MH organizations. In 1972, multiservice mental health organizations totaled only 6 percent of all partial care facilities, but constituted 62 percent of all partial care facilities in 1986.

Tables 4.11 and 4.12 present the changes in MH partial care additions and their rate per 100,000 population. Overall, additions increased by 150 percent from 1972 to 1986, and the rate of such care by 113 percent.

Summary of Changes in the MH Service System

In total, the number of MH facilities providing any level of psychiatric care increased by almost 2,800 from 1972 to 1986. This includes an increase of 1,126 inpatient facilities, 675 outpatient facilities, and 962 partial care facilities. Similarly, the number of patients being treated in these three setting types increased. The rate of inpatient additions increased by 16 percent, outpatient additions by 71 percent, and partial care additions by 113 percent. The only actual decrease occurred in State and county mental hospitals. Shorter inpatient stays accounted for most of the decrease in total days of care.

The major sources of inpatient care in 1972 were State and county mental hospitals (42 percent of all inpatient episodes) and general hospitals with psychiatric units (30 percent of episodes). By 1986, the pattern had reversed such that general hospitals with units had twice the number of episodes (34 percent) as State and county hospitals (17 percent).

Outpatient care was mostly divided between freestanding outpatient clinics, CMHCs, and non-Federal general hospitals with outpatient psychiatric units in 1971. These facilities accounted for 80 percent of all outpatient additions in that year. In 1986, over half of all outpatient additions were to multiservice ("All other") MH organizations (some of which were formerly CMHCs) and nearly 20 percent were to non-Federal general hospital outpatient clinics.

In 1971, CMHCs accounted for the largest share of partial care additions (28 percent) followed by State and county mental hospitals (22 percent) and non-Federal general hospitals with psychiatric units (15 percent). By 1986, 65 percent of all partial care additions were to multiservice MH organizations, 21 percent to general hospitals, and only 3 percent to State and county mental hospitals.

B. Chemical Dependency Service System

Much alcohol and drug treatment occurs in the MH service system described above. However, surveys of the MH system exclude some facilities treating chemical dependency that are not associated with a medical facility or not considered a hospital. Residential centers and halfway houses not associated with a medical facility are examples of such facilities.

The data in this section are drawn from NDATUS surveys, which are the best source of information on the specialty chemical dependency treatment system. These data overlap with that shown in the previous MH section, especially for units that are located in, or under the direct control of a hospital. Because of differences between NIMH and NDATUS surveys, it was impossible to remove such duplications from these counts (see Appendix C). Additionally, because of changes in definitions and survey methodologies over time, data on the numbers of specialty treatment units do not provide useful information to assess trends in facilities. Therefore, this section is limited to providing data available from surveys of individuals in treatment.

Available survey data are from chemical dependency treatment units, either freestanding or units of hospitals. There is also a large treatment network that neither NIMH nor NDATUS surveys address, consisting of psychologists, social workers, private physicians, and Alcoholics Anonymous and other self-help groups. Such providers make up a large segment of alcohol treatment (well over a million patients in 1977), and the same may also be true of drug treatment. Based on 1977 data, at least as many patients may be treated by private office-based physicians as are treated in general hospital units. One-half to two times as many may be involved in self-help organizations.

The NDATUS statistics on 24-hour care do not include general hospital patients treated outside of the chemical dependency unit or in a psychiatric unit. Estimates based on HDS data indicate that for 1980 there were 251,344 alcohol or drug disorder episodes that were treated in general medical beds of general hospitals that would not have been counted by either the NIMH or the NDATUS surveys and another 29,000 treated in psychiatric units that would not have been counted by NDATUS. For 1985 these

numbers are 311,000 (in general medical beds) and 70,000 (in psychiatric units) respectively. Within general hospitals from 1980 to 1985 there was an 8 percent increase in alcohol disorders (50,000 episodes) and a 9 percent decrease in mental disorders (90,000), with drug disorders constant.

Despite these changes, mental health problems accounted for approximately two-thirds of ADM inpatient discharges in both 1980 and 1985. Further, although data are presented separately for alcohol and drug services, 80 percent of substance abuse programs now treat both types of problems (Committee for the Substance Abuse Coverage Study, 1990). Some patients in substance abuse programs are also treated for mental disorders.

Alcohol Treatment System

Prior to the establishment of the National Institute on Alcoholism and Alcohol Abuse (NIAAA) in 1971, alcohol and alcohol abuse problems were largely ignored (Lewis, 1988). In the late 1960's specialized detoxification facilities were developed to treat public inebriates (considered criminal behavior at the time). These facilities expanded rapidly following widespread adoption by States of the 1974 Uniform Alcoholism and Intoxication Treatment Act decriminalizing public intoxication (Lewis, 1988). These detoxification centers were initially integrated with hospital emergency services.

The 1976 reauthorization of NIAAA increased incentives for States to enact laws decriminalizing public drunkenness and extended to outpatient facilities the provisions barring discrimination against alcoholics (P.L. 94-371). The 28-day treatment center (Weismann, 1988) and community-based treatment systems (Olson, 1988) sprang up after the creation of NIAAA. Even so, until 1977 there was no single agency responsible for information on alcohol abuse or treatment. (Harford et al., 1988). Between 1980 and 1985, the number of commercial insurance companies covering alcohol and drug treatment increased (Brady, Sharfstein, and Muszynski, 1986), and commercial insurance paid for an increase of 50,000 discharges with primary diagnosis of alcohol dependency in general hospitals (Kiesler and Simpkins, 1990).

Table 4.13 shows an estimate of the number of people served on a single day of each year for 1978-1989. The number of people treated in 24-hour (inpatient or residential) specialty services decreased modestly across this period. (This trend may have been counterbalanced by the modest increase in inpatient treatment of alcohol disorders within general hospitals.) At the same time, the number treated in less than 24-hour (outpatient, partial care or day care) services on any day increased by about 134,000 (71 percent). The total number of persons in specialty alcohol treatment on any day increased 50 percent between 1978 and 1989.

Drug Abuse Treatment System

While ambulatory care appears to be increasingly emphasized in alcohol treatment, no clear trend is evident for drug treatment. From 1976 to 1989, the numbers of people treated on any day in 24-hour (inpatient or residential) care increased more than 50 percent (Table 4.14). Outpatient care increased slightly less (39 percent). These increases significantly exceeded the population rate of growth.

Summary of the Chemical Dependency Service System

Little is known about the system for treatment of chemical dependency as it existed prior to 1977, and the data available since that time is sketchy. Nevertheless, there is reasonable evidence that the overall rate of alcohol treatment has increased significantly since then, due to large increases in outpatient or other nonresidential care. For drug treatment, the number of persons receiving specialty services on any day has increased for all types of service, and has exceeded the rate of population growth.

C. Long Term Care

As State and county hospitals have increasingly reduced their inpatient populations and length of care, NFs have become an important sector of ADM service delivery. For this report both SNFs and ICFs (now classified as NFs) are included under the general heading of "nursing homes."

Table 4.15 shows the data available regarding nursing homes and their treatment of ADM disorders. In 1972, there were about 17,600 nursing homes with 1.1 million admissions for the year. By 1985 this number had grown to somewhat over 20,000 nursing homes, two-thirds of which were proprietary, with 1.5 million admissions per year. Since 1973 the proportion of nursing home residents with a primary diagnosis of mental disorder (other than senility) has remained at 22-25 percent of total residents. Estimates suggest that 50 percent of State hospital releases were to nursing homes during the 1970's (Donahue, 1978; Frisman and McGuire, 1989). Nevertheless, it appears that these discharges only account for a minority of the increase in ADM disorders in nursing homes (Kiesler and Sibulkin, 1987).

D. Summary of Trends

ADM services can be provided in inpatient or outpatient settings. In addition, partial care settings offer a level of care more intensive than outpatient care, but less than the 24-hour a day services provided in inpatient or residential care. Facilities providing alcohol or drug services specialize in such treatment, but those providing MH services may also treat those with alcohol or drug problems.

Although the number of MH facilities increased by 53 percent between 1972-1986, the proportion that were classified as inpatient, outpatient, or partial care remained fairly stable. Partial care accounted for 20-25 percent of MH facilities, with the remainder evenly divided between inpatient and outpatient. Nevertheless, the particular types of facilities changed significantly over this period. For MH inpatient care, there was a reduction in CMHCs (through reclassification) and RTCs. Care provided by State and county mental hospitals decreased dramatically, with a drop of two-thirds in beds and annual days of care. In contrast, care provided within general hospitals increased greatly, and now accounts for more than half of all MH inpatient episodes. Private psychiatric hospitals experienced the greatest rate of growth, but only accounted for approximately the same percentage of episodes in 1986 (10 percent) as in 1972. In 1986, more people were being treated in more facilities, with fewer beds than in 1972. This was possible because the length of stay for MH inpatient episodes decreased from a mean of over 70 days in 1972 to 34 days in 1986, allowing fewer beds to serve more patients. However, while most MH inpatient facilities increasingly emphasize acute care, general hospitals have much shorter lengths of stay.

The number of MH outpatient additions doubled from 1971 to 1986. Although freestanding outpatient clinics were the major provider of such care in the early 1970's, by 1986 multiservice mental health organizations were the major type of MH outpatient facility. Part of this shift was due to reclassification, rather than the creation or elimination of specific facilities.

Trends in MH partial care facilities and additions were quite similar to those of the outpatient facilities. The number of partial care facilities increased by 98 percent between 1972 and 1986, and new annual additions increased by 150 percent. Most of this increase was in multiservice MH organizations which went from 11 percent of the partial care additions in 1972 to 65 percent of these additions in 1986.

From 1978 to 1989, the rate of inpatient alcoholism treatment decreased, while outpatient and partial care treatment increased by half. The rate of both inpatient and outpatient drug treatment increased, with the greatest proportional gains in inpatient and residential care. While specialty alcohol services are moving from inpatient care to ambulatory treatment, no trend is evident for drug services.

Role of the IMD Policy

The relationship of the IMD policy to changes in the ADM service system is difficult to assess. First, no direct statistics are available on facilities that could be classified as IMDs. Second, because the IMD policy only affects Medicaid services, facilities that do not accept Medicaid patients are unaffected by the policy even if they meet IMD criteria. Finally, some individual facilities have been designated as IMDs even though they are a type of facility that does not usually specialize in psychiatric treatment (e.g., nursing homes).

Despite these limitations, some provisional conclusions may be drawn as to the consequences of the IMD policy for changes in the ADM service system since 1972. The IMD exclusion applies to ADM inpatient (residentially-based) treatment, specifically to those facilities that specialize in such care. Since the general trend in the total system has been to outpatient or partial care since 1972, this means that the IMD policy now potentially limits Medicaid payment for a smaller proportion of total ADM services (although the total expenditures in this sector are probably greater). The relatively recent change in the IMD definition to exclude facilities of under 17 beds should further reduce this proportion.

It is also likely that the IMD policy affects a smaller proportion of ADM inpatient care than in the early 1970's. The two types of inpatient facilities most clearly meeting the IMD criteria are State and county mental hospitals, and private psychiatric hospitals. From 1972 to the mid-1980's, the proportion of total MH inpatient days accounted for by these types of facilities declined by 30 percent. The IMD policy very possibly contributed to this trend.

Table 4.1

NUMBER OF INPATIENT MH FACILITIES BY TYPE OF FACILITY

FACILITY TYPE	1972	1974	1976	1978	1980	1982	1984	1986	Change 1972-86	% Change
State & County MH	321	320	303	297	280	277	277	285	-36	-11%
Private Psych Hosp	156	180	182	188	188	211	220	314	158	101%
Non-Fed GH w/unit	653	684	791	843	843	1059	1259	1287	634	97%
VA Medical Ctr	110	112	112	121	121	127	124	124	14	13%
Fed.Fund CMHC	287	391	517	555	691	a/	-	-	-287	N/A
RTC for Children	344	340	331	375	368	339	322	437	93	27%
All other	42	33	37	42	39	292	647	592	550	1310%
Total	1913	2060	2273	2421	2530	2305	2849	3039	1126	59%

a/ Facilities that were classified as CMHCs prior to 1981 were reclassified into multiservice mental health organizations, general hospital psychiatric units or freestanding psychiatric clinics, depending on the services offered by the facility. This accounts for the increase in general hospital units and "all other organizations" between 1980 and 1982.

Sources:

Taube, C. A., & Barrett, S. A. (Eds.). (1983). Mental Health, United States 1983 DHHS Pub. No. (ADM)83-1275. Washington, DC: U.S. Government Printing Office.

Taube, C. A., & Barrett, S. A. (Eds.). (1985). Mental Health, United States 1985 DHHS Pub. No. (ADM)85-1378. Washington, DC: U.S. Government Printing Office.

Manderscheid, R. W., & Barrett, S. A. (Eds.). (1987). Mental Health, United States 1987 DHHS Pub. No (ADM)87-1518. Washington, DC: U.S. Government Printing Office.

Manderscheid, R. W., & Sonnenschein, M. A. (Eds.). (1990). Mental Health, United States 1990 DHHS Pub. No. (ADM)90-1708. Washington, DC: U.S. Government Printing Office.

Table 4.2

NUMBER OF MH INPATIENT BEDS BY FACILITY TYPE

	1972	1974	1976	1978	1980	1982	1984	1986	Change 1972-86	% Change
FACILITY TYPE										
State & County MH	360178	279274	222202	184079	156482	140140	130411	119033	-241145	-67%
Private Psych Hosp	14412	15369	16091	16637	17157	19011	12474	30201	15789	110%
Non-Fed GH w/unit	23278	24488	28706	29384	29384	36525	46045	45808	22530	97%
VA Medical Ctr	42305	39995	35913	33796	33797	24646	23546	26874	-15431	-37%
Fed. Fund CMHC	10540	12391	17029	14816	16264	a/	-	-	-10540	N/A
RTC for Children	19348	19023	18029	20071	20197	18475	16745	24547	5199	27%
All other	1787	1581	993	2228	1433	8515	24452	21150	19363	1087%
Total	471848	392121	338963	301011	274714	247312	253673	267613	-204235	-43%

a/ Facilities that were classified as CMHCs prior to 1981 were reclassified into multiservice mental health organizations, general hospital psychiatric units or freestanding psychiatric clinics, depending on the services offered by the facility. This accounts for the increase in general hospital units and "all other organizations" between 1980 and 1982.

Sources:

Taube, C. A., & Barrett, S. A. (Eds.). (1983). Mental Health, United States 1983 DHHS Pub. No. (ADM)83-1275. Washington, DC: U.S. Government Printing Office.

Taube, C. A., & Barrett, S. A. (Eds.). (1985). Mental Health, United States 1985 DHHS Pub. No. (ADM)85-1378. Washington, DC: U.S. Government Printing Office.

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Manderscheid, R. W., & Sonnenschein, M. A. (Eds.). (1990). Mental Health, United States 1990 DHHS Pub. No. (ADM)90-1708. Washington, DC: U.S. Government Printing Office.

Table 4.3

MH INPATIENT EPISODES

FACILITY TYPE	1971-72	1973-74	1975-76	1977-78	1979-80	1981-82	1983-84	1985-86	Change 1972-86	% Change
State and County										
Mental Hospitals	745259	652000	598993	574226	526690	499169	459374	445181	-300078	-40%
Private										
Psych Hospitals	97963	123000	137025	150685	150535	176513	180822	258255	160292	164%
VA Medical Center	176800	208000	214264	217507	217507	205580	170508	203851	27051	15%
General Hosp.										
With unit	542642	487787	565696	571725	571725	676941	820030	883119	340477	63%
Other	193152	260000	301130	331947	313130	162189	229879	265165	72013	37%
Fed fund CMHC	130088	192000	246891	268966	254288	a/	-	-	-130088	N/A
RTC for Children	28637	29000	28302	33504	33729	34426	32544	47204	18567	65%
All other	34427	39000	25937	29477	25113	127763	197335	217961	183534	533%
Total NIMH Episodes	1755816	1730787	1817108	1846090	1779587	1720392	1860613	2055571	299755	17%
General Hospitals b/										
no unit	507358	630059	777878	875475	982681	888350	684773	535359	28001	6%
Total	2263174	2360846	2594986	2721565	2762268	2608742	2545386	2590930	327756	15%

a/ Facilities that were classified as CMHCs prior to 1981 were reclassified into multiservice mental health organizations,general hospital psychiatric units or freestanding psychiatric clinics, depending on the services offered by the facility. This accounts for the increase in general hospital units and "all other organizations" between 1980 and 1982.

b/ General Hospitals with NO unit are discharges from short-stay hospitals, while all NIMH totals are episodes that do not consider the hospital as short or long stay. The general hospital, no unit total was arrived at by subtracting NIMH reported General hospitals with units, and the estimated short-term psychiatric specialty episodes from the total for the Hospital Discharge Survey for the year. This procedure underestimates the general hospitals without units because episodes are being subtracted from discharges.

Sources:

Taube, C. A., & Barrett, S. A. (Eds.). (1983). Mental Health, United States 1983 DHHS Pub. No. (ADM)83-1275. Washington, DC: U.S. Government Printing Office.

Taube, C. A., & Barrett, S. A. (Eds.). (1985). Mental Health, United States 1985 DHHS Pub. No. (ADM)85-1378. Washington, DC: U.S. Government Printing Office.

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Table 4.4

ADDITIONS TO MH INPATIENT FACILITIES

Rate per 100,000 civilian population

	1971	1973	1975	1977	1979	1981	1983	1986	Change 1971-86	% Change
TOTAL CIVILIAN POPULATION (in millions)	204.9	209.6	213.8	218.1	223.0	227.8	232.1	238.4	33.5	16%
FACILITY TYPE										
State & county mental hospitals	232.5	212.7	205.1	193.2	172.0	162.8	146.0	139.1	-93.4	-40%
Private psychiatric hospitals	42.6	52.6	59.4	64.3	63.2	71.2	70.9	98.0	55.4	130%
Non-federal general hospital psych unit	254.5	225.1	257.2	256.7	256.7	284.7	336.8	354.8	100.3	39%
V.A. Medical centers	65.6	81.3	85.5	84	84.0	71.5	64.3	75.1	9.5	14%
CMHC	37.2	88.0	111.7	119.9	110.6	-	-	-	-37.2	N/A
RTC for Children	5.5	5.8	5.7	7.1	6.9	7.8	7.1	10.2	4.7	85%
All other	16.3	14.5	11.9	12.9	10.8	53.2	76.3	82.7	66.4	407%
TOTAL	654.2	680.0	736.5	735.1	704.2	651.2	701.4	759.9	105.7	16%

Sources:

Taube, C. A., & Barrett, S. A. (Eds.). (1983). Mental Health, United States 1983 DHHS Pub. No. (ADM)83-1275. Washington, DC: U.S. Government Printing Office.

Manderscheid, R. W., & Barrett, S. A. (Eds.). (1987). Mental Health, United States 1987 DHHS Pub. No (ADM)87-1518. Washington, DC: U.S. Government Printing Office.

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Table 4.5

TOTAL DAYS OF MH INPATIENT CARE BY FACILITY TYPE
(In thousands)

FACILITY TYPE	1971-72	1973-74	1975-76	1977-78	1979-80	1981-82	1983-84	1985-86	Change 1971-86	% Change
State & Cnty MH	119200	92210	70584	57206	50589	44558	42427	39075	-80125	-67%
Priv. Psych Hosp	4220	4108	4401	4792	5074	5578	6010	8568	4348	103%
VA Med Ctr	14277	12985	11725	10628	10628	7591	7425	7753	-6524	-46%
Non Fed GH/w unit	6826	6990	8349	8435	8435	10727	12529	12570	5744	84%
Other	9116	10082	9911	11023	10559	8599	13430	15447	6331	69%
Fed fund CMHC	2225	3276	3718	3818	3609	a/	-	-	-	N/A
RTC for Children	6356	6338	5900	6546	6531	6127	5776	8267	1911	30%
All other	535	468	293	659	419	2472	7654	7180	6645	1242%
Total NIMH days	153639	126375	104970	92084	85285	77053	81821	83143	-70226	-46%
General Hospital no unit b/	5515	5174	5448	5867	7215	6087	4096	4296	-1219	-22%
Total	159154	131549	110418	97951	92500	83140	85917	87709	-71445	-45%

a/ Facilities that were classified as CMHCs prior to 1981 were reclassified into multiservice mental health organizations, general hospital psychiatric units or freestanding psychiatric clinics, depending on the services offered by the facility. This accounts for the increase in general hospital units and "all other organizations" between 1980 and 1982.

b/ Data for general hospitals without psychiatric units are from the Hospital Discharge Survey conducted by the National Center for Health Statistics.

Sources:

Taube, C. A., & Barrett, S. A. (Eds.). (1983). Mental Health, United States 1983 DHHS Pub. No. (ADM)83-1275. Washington, DC: U.S. Government Printing Office.

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Table 4.6

AVERAGE DAYS OF MH INPATIENT CARE PER EPISODE BY FACILITY TYPE a/

FACILITY TYPE	1971-72	1973-74	1975-76	1977-78	1979-80	1981-82	1983-84	1985-86	Change 1971-86	% Change
State & Cnty MH	159.9	141.4	117.8	99.6	96.1	89.3	92.4	87.8	-72.1	-45%
Priv. Psych Hosp	43.1	33.4	32.1	31.8	33.7	31.6	33.2	33.2	-9.9	-23%
VA Med Ctr	80.8	62.4	54.7	48.9	48.9	36.9	43.5	38.0	-42.8	-53%
Non Fed GH/w unit	12.6	14.3	14.8	14.8	14.8	15.8	15.3	14.2	1.6	13%
Other	47.2	38.8	32.9	33.2	33.7	53.0	58.4	58.3	11.1	24%
Fed fund CMHC	17.1	17.1	15.1	14.2	14.2	b/	-	-	-17.1	N/A
RTC for Children	222.0	218.6	208.5	195.4	193.6	177.9	177.5	175.1	-46.9	-21%
All other	15.5	12.0	11.3	22.4	16.7	19.3	38.8	32.9	17.4	112%
General hospital no unit c/	10.9	8.2	7.0	6.7	7.3	6.9	6.0	8.0	-2.9	-27%
Total	70.3	55.7	42.6	36.0	33.5	31.9	33.8	33.9	-36.4	-52%

a/ This table is derived from Tables 3 and 5 (total days of care divided by total episodes).

b/ Facilities that were classified as CMHCs prior to 1981 were reclassified into multiservice mental health organizations, general hospital psychiatric units or freestanding psychiatric clinics, depending on the services offered by the facility. This accounts for the increase in general hospital units and "all other organizations" between 1980 and 1982.

c/ For general hospitals without psychiatric units, average length of stay is based on discharged patients only.

Table 4.7

NUMBER OF FACILITIES PROVIDING MH OUTPATIENT SERVICES
BY FACILITY TYPE

FACILITY TYPE	1972	1974	1976	1978	1980	1982	1984	1986	Change 1972-86	% Change
State & County MH	238	173	147	121	100	91	86	83	-155	-65%
Private Psych Hosp	100	64	60	62	54	70	77	114	14	14%
Non-Fed GH w/unit	322	307	303	299	299	529	504	497	175	54%
VA Medical Ctr	102	104	113	127	127	130	132	137	35	34%
Fed.Fund CMHC	287	391	517	555	691	a/	-	-	-287	N/A
RTC for Children	66	49	57	62	68	60	63	99	33	50%
Freestand. Psy Clinic	1123	1092	1076	1160	1053	1473	792	773	-350	-31%
All other	33	39	45	43	39	292	1184	1243	1210	3667%
Total	2271	2219	2318	2429	2431	2645	2838	2946	675	30%

a/ Facilities that were classified as CMHCs prior to 1981 were reclassified into multiservice mental health organizations, general hospital psychiatric units or freestanding psychiatric clinics, depending on the services offered by the facility. This accounts for the increase in general hospital units and "all other organizations" between 1980 and 1982.

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Table 4.8

NUMBER OF MH OUTPATIENT ADDITIONS BY FACILITY TYPE

FACILITY TYPE	1971	1973	1975	1977	1979	1981	1983	1986	Change 1971-86	% Change
State & County MH	129133	167647	146078	107692	81919	73265	84309	62212	-66921	-52%
Private Psych Hosp	18250	31656	32879	33573	30004	69660	77589	123355	105105	576%
Non-Fed GH w/unit	282677	238208	254665	224284	224284	323341	469499	493801	211124	75%
VA Medical Ctr	51645	68016	93935	120243	120243	111810	103377	125280	73635	143%
Fed.Fund CMHC	335648	486585	784638	876121	1222305	a/	-	-	-335648	N/A
RTC for Children	10156	10993	19784	18155	19653	20947	32769	61855	51699	509%
Freestand. Psy Clinic	484677	650034	870649	861411	825046	1306451	538312	390630	-94047	-19%
All other	66636	60891	87151	101881	111273	541846	1360088	1509385	1442749	2165%
Total	1378822	1714030	2289779	2343360	2634727	2447320	2665943	2766518	1387696	101%

a/ Facilities that were classified as CMHCs prior to 1981 were reclassified into multiservice mental health organizations, general hospital psychiatric units or freestanding psychiatric clinics, depending on the services offered by the facility. This accounts for the increase in general hospital units and "all other organizations" between 1980 and 1982.

Sources:

Taube, C. A., & Barrett, S. A. (Eds.). (1983). Mental Health, United States 1983 DHHS Pub. No. (ADM)83-1275. Washington, DC: U.S. Government Printing Office.

Taube, C. A., & Barrett, S. A. (Eds.). (1985). Mental Health, United States 1985 DHHS Pub. No. (ADM)85-1378. Washington, DC: U.S. Government Printing Office.

Manderscheid, R. W., & Barrett, S. A. (Eds.). (1987). Mental Health, United States 1987 DHHS Pub. No (ADM)87-1518. Washington, DC: U.S. Government Printing Office.

Manderscheid, R. W., & Sonnenschein, M. A. (Eds.). (1990). Mental Health, United States 1990 DHHS Pub. No. (ADM)90-1708. Washington, DC: U.S. Government Printing Office.

Table 4.9

ADDITIONS TO MH OUTPATIENT FACILITIES

Rate per 100,000 civilian population

	1971	1973	1975	1977	1979	1981	1983	1986	Change 1971-86	% Change
TOTAL CIVILIAN POPULATION (in millions)	204.9	209.6	213.8	218.1	223.0	227.8	232.1	238.4	33.5	16%
FACILITY TYPE										
State & county mental hospitals	63.2	80.6	69.1	50.2	36.8	32.2	36.3	26.0	-37.2	-59%
Private psychiatric hospitals	8.9	15.2	15.6	15.6	13.5	30.6	33.4	51.5	42.6	479%
Non-federal general hospital psych unit	138.4	114.5	120.5	104.5	104.5	142.0	202.1	206.3	67.9	49%
V.A. Medical centers	25.3	32.7	44.4	56.0	56.0	50.3	44.5	52.3	27.0	107%
CMHC	164.3	233.8	371.2	408.1	548.6	-	-	-	-164.3	N/A
RTC for Children	5.0	5.3	9.4	8.5	8.8	9.2	14.1	25.8	20.8	416%
Free standing psych clinic	237.2	312.4	411.8	401.2	370.3	573.9	231.7	163.2	-74.0	-31%
All other	32.6	29.2	41.2	47.4	49.9	238.0	585.4	630.6	598.0	1834%
Total	674.9	823.7	1083.2	1091.5	1188.4	1076.2	1147.5	1155.7	480.8	71%

Sources:

Taube, C. A., & Barrett, S. A. (Eds.). (1983). Mental Health, United States 1983 DHHS Pub. No. (ADM)83-1275. Washington, DC: U.S. Government Printing Office.

Manderscheid, R. W., & Barrett, S. A. (Eds.). (1987). Mental Health, United States 1987 DHHS Pub. No (ADM)87-1518. Washington, DC: U.S. Government Printing Office.

Manderscheid, R. W., & Sonnenschein, M. A. (Eds.). (1990). Mental Health, United States 1990 DHHS Pub. No. (ADM)90-1708. Washington, DC: U.S. Government Printing Office.

Table 4.10

NUMBER OF MH FACILITIES PROVIDING PARTIAL CARE BY FACILITY TYPE

FACILITY TYPE	1972	1974	1976	1978	1980	1982	1984	1986	Change 1972-86	% Change
State & County Mental Hosp	134	139	118	104	83	62	63	57	-77	-58%
Private Psychiatric Hosp	72	85	77	80	68	71	74	102	30	42%
General Hospital w/unit	174	192	176	165	165	340	344	281	107	62%
VA Medical Center	49	62	69	67	67	66	65	63	14	29%
Fed.Fund CMHC	287	391	517	555	691	a/	-	-	-287	N/A
RTC for Children	60	96	106	114	104	64	69	123	63	105%
Freestand. Psy clinic	146	242	314	389	381	662	88	-	-58	N/A
All other	59	74	70	97	89	290	1114	1317	1258	2132%
Total	981	1281	1447	1571	1648	1555	1817	1943	962	98%

a/ Facilities that were classified as CMHCs prior to 1981 were reclassified into multiservice mental health organizations, general hospital psychiatric units or freestanding psychiatric clinics, depending on the services offered by the facility. This accounts for the increase in general hospital units and "all other organizations" between 1980 and 1982.

Sources:

Taube, C.A., & Barrett, S. A. (Eds.). (1983). Mental Health, United States 1983 DHHS Pub. No. (ADM)83-1275. Washington, DC: U.S. Government Printing Office.

Taube, C.A., & Barrett, S. A. (Eds.). (1985). Mental Health, United States 1985 DHHS Pub. No. (ADM)85-1378. Washington, DC: U.S. Government Printing Office.

Manderscheid, R. W. & Barrett, S. A. (Eds.). (1987). Mental Health, United States 1987 DHHS Pub. No (ADM)87-1518. Washington, DC: U.S. Government Printing Office.

Manderscheid, R. W., & Sonnenschein, M. A. (Eds.). (1990). Mental Health, United States 1990 DHHS Pub. No. (ADM)90-1708. Washington, DC: U.S. Government Printing Office.

Table 4.11

NUMBER OF MH PARTIAL CARE ADDITIONS BY TYPE OF MENTAL HEALTH ORGANIZATION

	1971	1973	1975	1977	1979	1981	1983	1986	1971-86 Change	% Change
FACILITY TYPE										
State & County Mental Hosp	16554	16793	14205	10697	9808	8302	3750	5774	-10780	-65%
Private Psychiatric Hosp	1894	2920	3165	3842	3467	6122	5642	8820	6926	365%
General Hospitals w/units	11563	18772	14216	12724	12724	38084	45926	39159	27596	238%
VA Medical Ctr	4023	7049	7788	6978	6978	8584	10189	7309	3286	81%
Fed. Fund CMHC	21092	59130	94092	102493	98332	a/	-	-	-21092	N/A
RTC for Children	994	1666	3431	3147	2519	2232	3380	5489	4495	452%
Freestanding Psych. Clinic	10642	15329	21928	21149	29587	59988	5451	-	-10642	N/A
All other	8783	7300	4501	9561	8916	32250	102994	122268	113485	1292%
Total	75545	128959	163326	170591	172331	155562	177332	188819	113274	150%

a/ Facilities that were classified as CMHCs prior to 1981 were reclassified into multiservice mental health organizations, general hospital psychiatric units or freestanding psychiatric clinics, depending on the services offered by the facility. This accounts for the increase in general hospital units and "all other organizations" between 1980 and 1982.

Sources:

Taube, C.A., & Barrett, S. A. (Eds.). (1983). Mental Health, United States 1983 DHHS Pub. No. (ADM)83-1275. Washington, DC: U.S. Government Printing Office.

Taube, C.A., & Barrett, S. A. (Eds.). (1985). Mental Health, United States 1985 DHHS Pub. No. (ADM)85-1378. Washington, DC: U.S. Government Printing Office.

Manderscheid, R. W. & Barrett, S. A. (Eds.). (1987). Mental Health, United States 1987 DHHS Pub. No (ADM)87-1518. Washington, DC: U.S. Government Printing Office.

Manderscheid, R. W., & Sonnenschein, M. A. (Eds.). (1990). Mental Health, United States 1990 DHHS Pub. No. (ADM)90-1708. Washington, DC: U.S. Government Printing Office.

Table 4.12

ADDITIONS TO MH PARTIAL CARE FACILITIES

Rate per 100,000 civilian population

	1971	1973	1975	1977	1979	1981	1983	1986	Change 1971-86	% Change
TOTAL CIVILIAN POPULATION (in millions)	204.9	209.6	213.8	218.1	223.0	227.8	232.1	238.4	33.5	16%
FACILITY TYPE										
State & county mental hospitals	8.1	8.1	6.7	5.0	4.4	3.6	1.6	2.4	-5.7	-70%
Private psychiatric hospitals	0.9	1.4	1.5	1.8	1.6	2.7	2.4	3.7	2.8	311%
Non-federal general hospital psych unit	5.7	9.0	6.7	5.9	5.9	16.7	19.8	16.4	10.7	187%
V.A. Medical centers	2.0	3.4	3.7	3.2	3.2	3.2	4.4	3.1	1.1	55%
CMHC	10.3	28.4	44.5	47.7	44.1	-	-	-	-10.3	N/A
RTC for Children	0.5	0.8	1.6	1.5	1.1	1.0	1.5	2.3	1.8	360%
Free standing psych clinic	5.2	7.4	10.4	9.9	13.3	26.3	2.3	-	-2.9	N/A
All other	4.3	3.5	2.1	4.5	4.0	14.2	44.3	51.1	46.8	1088%
Total	37.0	62.0	77.2	79.5	77.6	67.7	76.3	79.0	42.0	113%

Sources:

Taube, C.A., & Barrett, S. A. (Eds.). (1983). Mental Health, United States 1983 DHHS Pub. No. (ADM)83-1275. Washington, DC: U.S. Government Printing Office.

Manderscheid, R. W. & Barrett, S. A. (Eds.). (1987). Mental Health, United States 1987 DHHS Pub. No (ADM)87-1518. Washington, DC: U.S. Government Printing Office.

Manderscheid, R. W., & Sonnenschein, M. A. (Eds.). (1990). Mental Health, United States 1990 DHHS Pub. No. (ADM)90-1708. Washington, DC: U.S. Government Printing Office.

Table 4.13

NUMBER OF PERSONS IN ALCOHOL TREATMENT ON A SINGLE DAY BY TYPE OF CARE

TYPE OF SERVICE	1978	1980	1982	1987	1989	Change 1978-89	% Change
24 HOUR SERVICE							
Detox (medical)		7327	7285	6391	6577	-	-
Detox (social)		4289	4389	4001	3216	-	-
Rehab model		37171	33651	37491	35616	-	-
Custodial		4715	6282	2688	4598	-	-
Total	58973	53502	51607	50571	50007	-8966	-15%
Rate per 100,000 pop.	27.4	23.5	22.2	20.8	20.2	-7.2	-26%
< 24 HOUR SERVICE							
Ambulatory							
medical detox		2382	1356	-	-	-	-
Limited/day care		3642	11846	-	-	-	-
Outpatient		247648	225124	287333	324430	-	-
Total	190311	253672	238326	287333	324430	134119	71%
Rate per 100,000 pop.	88.3	111.4	102.7	118.3	131.2	42.9	49%
TOTAL	249284	307174	289933	337904	374437	125153	50%
Rate per 100,000 pop.	115.7	134.9	124.9	139.2	151.4	35.7	31%

Sources:

Vischi, T. R., Jones, K. R., Shank, E. L., & Lima, L. H. (1980). The Alcohol, Drug Abuse and Mental Health National Data Book. DHHS Publication No. (ADM) 80-938. Rockville, MD: U. S. Department of Health and Human Services.

Reed, P. G. (1983). National Drug and Alcoholism Treatment Utilization Survey. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

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Table 4.14

CLIENTS IN DRUG TREATMENT ON A SINGLE DAY
BY TYPE OF SERVICE AND TREATMENT MODALITY

TYPE OF SERVICE	1976	1978	1980	1982	1987	1989	Change 1976-89	% Change
TOTALS BY TREATMENT								
Drug free	153223	125119	105012	95874	167941	237013	83790	54%
Detox	10254	5614	6203	5146	10348	14801	4547	44%
Maintenance	74048	71572	67851	72010	81852	92715	18667	25%
Other	5546	384	3466	449	-	-	-5546	N/A
Total	243071	202689	182532	173479	260141	344529	101458	41%
TOTALS BY SERVICE								
Total inpatient/res.	34408	28899	25383	23996	37799	53817	19409	56%
Rate per 100,000 pop.	15.8	13.0	11.2	10.3	15.6	21.8	6.0	38%
Total outpatient	208663	173790	157149	149483	222342	290712	82049	39%
Rate per 100,000 pop.	95.7	78.1	69.0	64.4	91.6	117.5	21.8	23%
Total	243071	202689	182532	173479	260141	344529	101458	41%
Rate per 100,000 pop.	111.5	91.1	80.2	74.7	107.1	139.3	27.8	24%

Sources:

Vischi, T. R., Jones, K. R., Shank, E. L., & Lima, L. H. (1980). The Alcohol, Drug Abuse and Mental Health National Data Book. DHHS Publication No. (ADM) 80-938. Rockville, MD: U. S. Department of Health and Human Services.

National Institute on Drug Abuse (1976). Summary Report: Data from the National Drug Abuse Treatment Survey. Statistical Series F, No. 1. Rockville, MD: Alcohol, Drug Abuse, and Mental Health Administration.

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National Institute on Drug Abuse (1983). Main findings for drug abuse treatment units, September 1982. Statistical Series F, No. 10. Rockville, MD: Alcohol, Drug Abuse, and Mental Health Administration.

U. S. Department of Health and Human Services, Alcohol, Drug Abuse, and Mental Health Administration (1989). National Drug and Alcoholism Treatment Survey. 1987. DHHS Publication No. (ADM) 89-1626. Rockville, MD: U. S. Department of Health and Human Services, Alcohol, Drug Abuse, and Mental Health Administration.

U. S. Department of Health and Human Services, Alcohol, Drug Abuse, and Mental Health Administration. (1990). National Drug and Alcoholism Treatment Unit Survey. 1989. DHHS Publication No. (ADM)91-1729. Rockville, MD: Alcohol, Drug Abuse, and Mental Health Administration.

Table 4.15

CHARACTERISTICS OF NURSING HOMES AND NURSING HOME RESIDENTS

	1972a/	1973c/	1976e/	1977	1978c/	1980d/	1984e/	1985b/
Total Homes	17685	21834	23105f/	-	18722	23065	19100	20479
Total Beds	1174800	1327704	1414865c/	-	1348794	1537338	-	1624200
Bedsize								
<25	2918	7379	7162f/	-	5414	5798	-	-
25-49	4244	4563	4404f/	-	3185	3030	6341	-
50-99	6189	5807	6090f/	-	5306	5707	6208	-
100-199	3625	3362	3899f/	-	4817	4737	5367	-
200 or more	707	502	2041f/	-	-	1093	1184	-
Ownership								
Proprietary	-	-	17744	-	14023	18669	14325	-
Non-profit	-	-	4089	-	3485	3460	3763	-
Government	-	-	1270	-	1214	936	1012	-
Total Admissions	1110900	1075800	117500c/	1303100h/	-	-	1223500	1491400
Age								
<65	-	114300b/	136200	177100b/	-	-	133100	173100
>65	-	961500b/	981300	1126000b/	-	1396132e/	1090400	1318300
Diagnosis								
ADM Disorder	-	273200g/	568300f/	394200h/	-	-	-	331090
Primary Pay								
Own	-	-	419500	-	-	-	-	712500
Medicare	-	-	189600	-	-	-	-	71500
Medicaid	566599	-	392600	-	-	-	-	605800
Oth. Gov	-	-	42400	-	-	-	-	-
All Other	-	-	73300	-	-	-	-	101700

Sources:

a/ Sirrocco, A. (1977). Nursing Homes in the United States: 1973-74. National Center for Health Statistics. Vital and Health Statistics, Series 14(17).

b/ Hing, E. (1989). Nursing Home Utilization by Current Residents, 1985. National Center for Health Statistics. Vital and Health Statistics, Series 13(102).

c/ Strahan, G. W. (1981). Inpatient Health Facilities Statistics United States, 1978. National Center for Health Statistics. Vital and Health Statistics, Series 14(24).

d/ Sirrocco, A. (1980). Nursing and Related Care Homes: as reported from the 1980 NMFI Survey. National Center for Health Statistics. Vital and Health Statistics, Series 14(29).

e/ Sekscenski, E. (1990). Discharges from Nursing Homes: 1985 National Nursing Home Survey. National Center for Health Statistics. Vital and Health Statistics, Series 13(103).

f/ Zappolo, A. (1981). Discharges from Nursing Homes: 1977 National Nursing Home Survey. National Center for Health Statistics. Vital and Health Statistics, Series 13(54).

g/ Ingram, D. (1977) Profile of chronic illness in nursing homes. United States. National Center for Health Statistics. Vital and Health Statistics, Series 13(29).

h/ Hing, E. (1981) Characteristics of Nursing Homes Residents, Health status, and Care Received: National Nursing Home Survey. National Center for Health Statistics. Vital and Health Statistics, Series 13(51).

CHAPTER V

Cost-Effectiveness of Types of ADM Care

Outcome studies of ADM services may analyze the relative costs and benefits, or the effectiveness per unit cost of programs or treatments. The terms "cost-benefit" and "cost-effectiveness" seem similar, but are really quite different. Cost-benefit analysis requires that both costs and benefits be assigned monetary values and that their ratio or difference be examined for different treatments or programs. Costs for these analyses generally include the value of the resources used in the treatment and the social and economic costs incurred when treatment is absent or ineffective. In a cost-benefit analysis of psychiatric treatment, costs would include not only direct service costs, but other variables such as days lost from work to attend treatment. Benefits would incorporate some economic valuation of increased well-being resulting from treatment as well as such effects as reductions in subsequent medical and criminal justice costs, or increased employment.

By contrast, cost-effectiveness analysis is a more limited comparison of the direct costs and health effects of alternative treatments. A common outcome is specified and the costs of alternative treatments are examined. Costs are specified in monetary terms but usually include only the treatment program costs (Saxe, Dougherty, Esty, and Fine, 1983). In essence, cost-effectiveness studies attempt to determine which treatment or program accomplishes a given objective most cheaply (e.g., using a measure such as cost per drug-free day). Because cost-effectiveness studies are more narrowly focused than cost-benefit ones and because programs are not uniform in their results, the relative desirability of a particular treatment or program may vary depending upon the particular cost-effectiveness measure that is specified. Although cost-effectiveness studies are more limited than cost-benefit analyses, they are still relatively rare due to the expense and difficulty of conducting them.

Especially in the assessment of alcohol programs, cost-effectiveness analysis may include estimates of cost offset (Institute of Medicine, 1989). Cost offset determines if a treatment lowers costs elsewhere in the health care system to the extent that the savings offset the treatment costs. Much of the research on "effectiveness" of treatment deals with medical cost offset. For the purposes of this report, "cost offset" is used to refer to comparisons of pre- and post-treatment medical costs.

Both cost-benefit and cost-effectiveness studies are difficult to conduct. Outcomes may be poorly specified or difficult to measure with precision. For instance, some outcome data may be based on self report, which may be inaccurate or biased toward socially desirable responses. Random assignment may not be possible and comparison groups may therefore differ in unknown ways. Determining associated costs imposes additional problems. By some methodological standards, cost-benefit studies are nonexistent, due to the great difficulty in assigning monetary values to non-price variables (e.g., personal

well-being). However, even for variables to which prices can be assigned, measurement may be difficult or not reflect true market-based costs.

Types of Settings

In investigating the efficacy and costs of alternative care, it is important to understand how it differs from traditional inpatient care. There are four major setting types: inpatient, residential, partial hospitalization, and outpatient.

Inpatient care, at a minimum, is characterized as 24-hour per day care that includes skilled nursing staff. Within this setting, treatment may be purely custodial or include a range of clinical programming from individual therapy to multidisciplinary intensive group treatment. In the case of inpatient treatment for chemical dependency, detoxification and medical management of associated physical symptomatology may be provided. Length of care may range from a few days to years.

"Residential treatment" usually refers to nonmedical or independent treatment facilities that provide room and board, and treatment or support that may range from a few hours per week to 24-hour care. Professional medical personnel may or may not be part of the treatment staff. MH residential treatment includes such facilities as halfway houses and residential communities. Substance abuse residential treatment includes settings such as therapeutic communities and residential treatment centers. Similar to inpatient care, the lengths of stay in residential treatment settings vary widely.

Partial hospitalization is usually a 5-day per week, 6-8 hour per day program. The patient/client usually returns home for the night, and participates in the treatment program by day. A skilled nursing staff is usually on duty during the times of the treatment program, but treatment usually follows a multidisciplinary team approach. The programs provide a variety of activities for several treatment groups for each treatment day (Goldberg, 1988). Generally, long-term partial hospitalization is targeted to those suffering from chronic disorders (Lefkovitz, 1988; Luber, 1979), while short-term partial hospitalization of 3 to 10 weeks usually provides crisis stabilization for acute episodes (Lefkovitz, 1988). Partial hospitalization is used more commonly in MH treatment than in the treatment of chemical dependency.

Outpatient treatment usually consists of regularly scheduled treatment times ranging from daily to 1-2 times per month, with each session of 1 to 3 hours duration. The actual treatment varies with the outpatient program and may include any of the treatments provided in inpatient or partial hospitalization settings. Generally, a treatment session focuses on a single mode of treatment (i.e., individual therapy or medical management), but several modes may be combined in additional sessions (e.g., individual therapy on one day, family therapy on another).

These four treatment settings typically differ in the severity of the conditions they treat and the time the patient/client is required to spend in the setting. However, the setting alone does not necessarily dictate the type of treatment or the intensity of that

treatment. Different types of care can occur within each general type of setting and can vary by service area. For instance, outpatient drug treatment encompasses methadone maintenance programs as well as clinic-based programs for nonopiate treatment.

Costs per treatment episode with comparable effectiveness differ by setting type. Typically, partial hospitalization costs about two-thirds of that of inpatient hospital care when total costs of the treatment over a period of time are considered (e.g., Krowinski and Fitt, 1978; Washburn, Vannicelle, Longabaugh, and Scheff, 1976). Outpatient treatment cost savings are frequently reported as savings in inpatient days over an extended period of time (Hafner and der Heiden, 1989; Levenson, Lord, Sermas, Thornby, Sullender, and Comstock, 1977). These savings in inpatient days typically range from 50 to 80 percent. Available cost data indicate savings of about 80 percent during a specified period (Levenson et al., 1977; Sharfstein and Katz-Levy, 1984).

The distinction between inpatient, residential, partial hospitalization, and outpatient settings for treatment can be misleading when comparing the efficacy of alternative treatment programs. Treatment that is alternative to traditional inpatient hospital treatment may include treatment in any or all of these settings, or others. Alternative care treatments vary across programs in terms of professional involvement, supervision, and costs (Kiesler and Sibulkin, 1987). They may include the use of medication, psychiatric therapy, skills training, and contact with nonprofessionals. They often involve social systems intervention, basic support, and behavioral skill building.

The following sections review studies on the cost-effectiveness of ADM services. In addition, cost offset data are presented for drug and alcohol treatment. In general, data support the conclusions that any treatment is better than no treatment, and that the most cost-effective treatment is usually the least expensive of the alternatives. However, it is important that hospitalization for medical or psychiatric crisis be distinguished from treatment of the ADM disorder. Generally, the following sections deal with ADM treatment and not with crisis stabilization that may require immediate hospitalization.

A. Alcohol Abuse Services

Cost Offset

One of the earlier reviews of cost offset of alcohol treatment was carried out by Jones and Vischi (1979). While there were many problems with the 12 alcohol treatment studies they reviewed, the studies did show cost offsets in terms of reductions in medical care utilization or surrogate measures such as sick days. Using data from insurance and HMO plans, Holder (1987) and Holder et al. (1988) examined several large samples of persons with alcohol problems. Total medical costs before and for up to 3 years after treatment were compared. There was a universal decrease in total medical costs compared to past trends and with the control groups. These reductions occurred

regardless of the type of treatment or provider, and even minimal interventions resulted in lower subsequent medical costs.

Another set of studies focused on patients of VA and Medicaid programs (Magruder-Habib, Luckey, Mikow, Barrow, and Feits, 1985; Calkins, Kemp, Lock, Ramsey and Cohen, 1986). These studies found no cost offset and in some instances actually found an increase in medical care costs following treatment. Luckey (1987) interpreted these results as reflecting the more chronic health problems of the low income study population, who also had fewer incentives to maintain recovery.

The cost offset studies of alcohol treatment appear to show declines in medical costs and related expenses for people who are not poor. For those in poverty, the cost offset was not shown. This does not mean that the treatment was ineffective, only that health care costs were not reduced as a result of the alcohol treatment.

Cost-Effectiveness

Annis (1986) recently reviewed research on inpatient treatment of alcoholism and drew five conclusions: 1) Inpatient alcohol programs of various lengths show no higher success rates than periods of brief hospitalization of a few days. 2) The great majority of alcoholics seeking treatment can be safely detoxified without pharmacotherapy and in units not based in hospitals. Detoxification with pharmacotherapy on an ambulatory basis can be demonstrated to be an effective and safe alternative at one-tenth the cost. 3) Day programs (partial hospitalization) have equal or superior results to inpatient care at one-third to one-half the cost. 4) Well-controlled trials with random assignment to treatment condition find equal or superior outcomes by outpatient care compared to inpatient, at a fraction of the inpatient cost. 5) Recent evidence suggests some potential of matching patients to a "tailored" treatment (based on patient personality and/or demographic characteristics), which has promise of increasing improvement rates.

Another recent review of the effectiveness of alcohol treatment described the results of 26 controlled clinical trials (Miller and Hester, 1986a; 1986b). Length of treatment was compared in 13 of the studies, and ranged from 1 to 7 weeks. All showed no advantage of longer over shorter treatment, or of extended inpatient care over detoxification alone (Saxe and Goodman, 1988). Miller and Hester also found no difference between settings on outcomes such as health, employment, abstinence, or psychological status. They concluded that inpatient care was not more effective than outpatient care. A recent study, however, found that inpatient care plus attendance at Alcoholics Anonymous (AA) meetings was more effective on several measures than AA meetings alone (Walsh et al., 1991).

Most studies indicate that, regardless of treatment type, about 60 percent of alcoholics who seek treatment either quit drinking or significantly reduce it in any given month (Longabaugh et al., 1983; Wilner, Freeman, Surber, and Goldstein, 1985). Reviews of the research on the effectiveness of alcohol treatment suggest the simple conclusion that everything works reasonably well, but not spectacularly so. Types of inpatient care,

length of inpatient care, and inpatient care itself do not noticeably affect the efficacy of treatment. Indeed, in one experimental study with random assignment to treatment condition, a stern 2-hour lecture worked as well in reducing alcoholic behavior as 14 days of inpatient care (Chapman and Huygens, 1988).

The most general conclusion from studies of treatment of alcoholics is that there is no good evidence that one treatment setting is better than another. All work reasonably well, but they vary as much as 10 to 1 in costs (Miller and Hester, 1986a). One study, for example, found that inpatient care ranged from $3,319 to $3,665 per patient, while outpatient costs ranged from $175 to $388 (Hayashida et al., 1989). Since different treatment variations seem to work to about the same degree, it follows that the least expensive (usually outpatient treatment) is the most cost effective.

Some authors have suggested that these conclusions may be modified by studies of programs that match subgroups of patients with particular treatments. However, most of these programs have matched patients with particular types of therapists or therapies, rather than treatment settings. To date, no significant evidence has been produced that demonstrates that inpatient treatment is more effective or more cost-effective than other settings for any particular subgroup of patients.

B. Drug Abuse Services

Cost Offset

Medical cost offset for drug treatment has not been investigated in the literature. There are a few studies, however, that have investigated the societal costs or savings due to a treatment program. Although there are many design flaws in these studies, they demonstrate that the costs of chemical dependency, especially drug abuse, are far greater than those included in medical expenses alone.

One such study examined the effects on a community of closing a methadone maintenance program (McGlothlin and Anglin, 1981; Apsler and Harding, 1991). Two communities were compared, one with a continuing methadone maintenance program and one whose program closed. "Costs" were calculated as cost of treatment, arrest, jail, court processing, welfare costs and the like. The results showed that costs were about 17 percent greater for men in the community with the closed program than the comparison community. However, for women the costs were greater in the comparison community than in the community with the closed program. This strange reversal was explained by other differences between the two communities. Both property crime and welfare costs were higher in the comparison community.

Another study analyzed the crime-reducing effects of 41 drug abuse programs funded by the National Institute of Drug Abuse (NIDA) and the National Institute of Justice (Hubbard, Cavanaugh, Craddock, and Rachal, 1985; Hubbard et al., 1989). Samples of the clients were followed for up to 5 years. The study concluded that the substantial

reductions in crime-related and other costs to the nation are at least as large as the cost of providing the treatment.

Cost-effectiveness/Cost-benefit

There are a number of significant problems in drug treatment research that render it less conclusive than the comparable literature on alcoholism and mental disorders. These problems are not unique to drug treatment research but are probably more prevalent than in the other areas. They include the following: 1) Cost-effectiveness or cost-benefit studies of drug treatment are extremely rare. 2) In outcome studies, as many as 50 percent of "control group" patients improve. 3) Patients receiving drug treatment often are receiving treatment from more than one source (often unknown to the investigators), which confounds any conclusions regarding a specific treatment. "Untreated" subjects often receive treatment elsewhere, which contributes to the typical observation that no-treatment groups typically improve (Apsler and Harding, 1991). 4) Although the majority of patients in these studies are opiate abusers, multiple drug use is common and confounds findings. 5) "Successful" treatment studies very often find reduced opiate use, but also increased alcohol and/or other drug consumption. 6) Drug abuse studies employ much less adequate methodologies than those on alcoholism or mental health (e.g. Cross, Saxe, and Hack, 1988; Goldstein, Surber, and Wilner, 1984). 7) Even major studies, such as the Drug Abuse Reporting Program with over 4,600 patients, use retrospective interviews as a primary source of data. Most studies of retrospective interviews find current levels of drug use to be underreported, thereby exaggerating the effects of the treatment (e.g., Ostrea, Brady, Parks, and Arsenio, 1989). 8) Studies which find increased employment by treated patients also find that over one-half of them are employed by other drug treatment programs. 9) Studies often find that treatment effectiveness is maintained only as long as the patient remains in treatment, which raises questions of ultimate costs of treatment.
10) Little or no research has been conducted on certain subgroups of drug abusers that are of particular interest (e.g., pregnant women).

Despite these limitations, investigators do draw conclusions regarding inpatient and outpatient care. Cross, Saxe, and Hack (1988) reviewed research bearing on treatment for nonopiate drug abuse, including cocaine. They observed that long term treatment seems necessary for many substance abusers. They concluded that while treatment is better than no treatment, little or no evidence establishes the superiority of one type of setting over another. However, they also did not believe that the research was adequate to draw final conclusions about cost-effectiveness.

The Institute of Medicine (IOM) judged that there was insufficient information to draw conclusions about the cost-effectiveness of typical inpatient chemical dependency programs of 3 to 6 weeks duration (Committee for the Substance Abuse Coverage Study, 1990). However, it did find that a common theme of effective programs was that the longer one was in treatment of any kind, the greater the effectiveness of the program. The IOM also cited two studies to draw conclusions about the relative costs and benefits of methadone maintenance, residential therapeutic communities of 6

months or more duration, and outpatient nonmethadone treatment. One of these studies focused on the reduction in criminally-related costs (e.g., property damage) resulting from different types of treatment (Harwood, Hubbard, Collins, and Rachal, 1988). It found that methadone treatment had the best benefit-cost ratio using one set of variables while outpatient treatment had the best ratio using a more comprehensive set. The ratio for residential treatment fell between the other two for each of the methods.

The other study cited by the IOM was not limited to criminally-related costs, but attempted to estimate all of the relevant costs and benefits of drug treatment (Rufener, Rachal, and Cruze, 1977). These included effects on employment and mortality, and subsequent use of medical treatment. The IOM noted that the study generally found outpatient treatment to be less cost-effective than methadone programs or therapeutic communities (e.g., using a measure of treatment cost per opiate free day). However, when other variables such as medical and criminal justice costs were included, the study concluded that outpatient treatment had the highest benefit-cost ratio while therapeutic communities had the lowest.

Apsler and Harding (1991) recently completed a comprehensive review of the cost-effectiveness literature regarding treatment of drug abuse, incorporating a review by Anglin and Hser (1990). They concluded that a variety of treatment modalities are equally effective, with 60 percent of patients improving. Drop-out rates are high, except for some methadone maintenance programs. Similar to alcohol treatment, although various treatment modalities are equally effective, costs vary dramatically, leading to the conclusion that the least expensive is the most cost-effective.

C. Mental Health Services

The number of good studies that have examined alternatives to inpatient MH care are limited, but are generally consistent in their findings. Kiesler and Sibulkin (1987) reviewed 14 experimental studies involving random (or nearly random) assignment to inpatient hospital care or to alternative care outside a hospital. They found that the evidence clearly favored care outside a hospital. They also concluded that the alternative care was less expensive, partly as a result of reducing subsequent hospitalization. Other reviewers have drawn similar conclusions (Braun et al., 1981; Greene and De La Cruz, 1981).

Two major treatment models have been developed as alternatives to traditional MH inpatient care: residential communities and home-based services. Residential communities originally developed as small societies operated by ex-patients of mental institutions. These settings typically have multidisciplinary staffs, but no staff permanently reside on the premises and none are present during the evening hours. Members have certain roles they must perform. Treatment consists of modifying behaviors and perceptions and feeling about oneself and others through these social processes.

One of the first residential community programs was the Community Lodge developed by Fairweather and his colleagues (Fairweather, Sanders, Cressler, and Maynard, 1969). This program emphasizes the creation of autonomous residential settings administered by the patients, which often include a patient-run small business (e.g., a janitorial service). Evaluation of the Lodge program indicated that over a 5-year period the cost of the treatment appeared to be a third of that for inpatient care. However, costs for such programs varied, with some becoming completely self sufficient (Fairweather, 1980).

An opportunistic study of a residential community program occurred during a period when a mental health center was closed in Denver. Patients who ordinarily would have been hospitalized in the center were sent to a "hostel," which was a house in which staff were present on a part-time basis. A nurse visited the hostel once a day to dispense medications and other staff were on 24-hour call to handle crisis situations. Treatment generally focused on whatever part of the patient's social system was seen as the source of any crisis (usually the family). Brook (1973) examined the outcomes of the first 49 of the hostel patients and compared them to the last 49 patients hospitalized. There were no differences between the hostel group and the hospitalized group on 11 outcome measures, and fewer hostel residents were hospitalized in the 6 months following treatment.

In contrast to residential community treatment, home-based programs provide services to patients in their own homes. This contrasts with other modalities that require the patient to go to a treatment site. Staff often go to the patient, make themselves available for emergencies, and help the patient with problems.
The Sacramento Project, a home-based treatment program in Colorado (Flomenhaft, Kaplan, and Langsley, 1969; Langsley, Machotka, and Flomenhaft, 1971), randomly assigned patients to family crisis therapy and regular inpatient care. Typical family crisis therapy consisted of office visits, home visits, and telephone contacts. The first home visit was made within 4 hours of the initial contact. The team worked with all members of the patient's immediate family.

The family crisis therapy group was seen by a team for 2.5 weeks while the inpatient group stayed an average of 26 days in the hospital. After 6 months the alternative care group was doing as well as the hospitalized group on two measures of functioning, and returned to prestress functioning much more rapidly (Flomenhaft et al., 1969). After 18 months, the inpatient group was found to have spent a total of 5,121 days in hospitals, while the alternative care group spent 1,859 days in hospitals (Langsley et al., 1971).

Perhaps the best known example of a home-based treatment program is the Training in Community Living (TCL) program in Madison, Wisconsin (Stein and Test, 1985), also called the Program for Assertive Community Treatment. The TCL program has been replicated in a variety of places (Thompson, Griffith, and Leaf, 1990; Olfson, 1990). Weisbrod, Test, and Stein (1980) estimated that the initial cost of the program was about $400 more than that of traditional inpatient treatment, but these costs included program start-up expenses. Patients in alternative treatment functioned better at the

end of 12 months than those treated in traditional inpatient units, most notably in terms of competitive employment. In subsequent years, the program was shown to produce about $400 per patient year in net benefits (e.g., including employment earnings). It also delivered more effective services in terms of patient rehabilitation and functioning.

Costs for home-based treatment are difficult to assess, since the treatment varies depending on the exact program. Nevertheless, studies of such programs have shown savings of anywhere from 10 percent to 90 percent compared to inpatient care (Bond, 1984; Fenton, Tessier, Contandriopoulos, Nguyen, and Struening, 1982; Gilman and Diamond, 1985; Weisbrod, et al., 1980; Witheridge and Dincin, 1985). Equally important, compared to inpatient or residential programs, patients prefer programs that allow them to live in their own apartment or house (Carling, 1990; Olfson, 1990).

D. Policy Implications

Inpatient Care

The research on types of ADM treatment generally finds that alternatives to traditional inpatient care are more cost-effective. Some experts have suggested that this conclusion may be modified as a result of studies that match particular subgroups of patients to particular treatments. However, no significant research currently exists to support this point of view.

Despite the evidence of the cost-effectiveness of treatment alternatives, few researchers advocate the elimination of ADM inpatient treatment. Inpatient care is still necessary for some ADM patients with associated physical problems, or for whom detoxification or other treatment necessitates 24-hour medical monitoring. Others may require an inpatient setting for involuntary commitment, due to a judgment that they are dangerous to themselves or others. In such cases, the inpatient setting is needed for the greater monitoring, supervision, and control it allows, rather than a different mode or intensity of treatment.

Such situations probably do not account for the majority of those receiving ADM inpatient care. The important question then is not whether inpatient programs should be eliminated, but to what degree they could be reduced if alternative care were more available. Although this issue has not been directly addressed in the scientific literature, several researchers have nevertheless attempted estimates for MH treatment. Test (1981) determined that with the home-based TCL program, only 15-25 percent of the patients ever needed inpatient care. This percentage included very short-term hospitalization for such things as the stabilization of medication, as well as longer term care. More recent work has not recalculated this percentage, but has demonstrated a significant decrease in the total days of inpatient care in the treatment population (Test, Knoedler, and Allness, 1985). Kiesler and Sibulkin (1987) concluded that the majority of MH inpatients can be more effectively treated outside a hospital.

Services for Pregnant Substance Abusers

Recently, particular attention has been paid to services available under Medicaid to pregnant substance abusers, particularly crack cocaine addicts. Although the overall rate of cocaine use has been declining, the number of those using crack cocaine and/or using cocaine on a daily basis appears to be increasing. Of particular concern is the increased use among women and the adverse effects on newborns of such utilization during pregnancy (GAO, 1991; Horgan et al., 1991).

As previously mentioned, a limitation of current drug abuse treatment studies is that some important subpopulations have not been studied. This is certainly true for pregnant substance abusers. In the absence of cost-effectiveness research specific to this population, the most reasonable assumption would be that the results that generally have been found for other types of substance abuse groups also would apply to this one. Therefore, judgement would lead to the expectation that the least expensive treatment would be the most cost-effective.

Some nevertheless claim that the problems and characteristics of pregnant substance abusers are significantly different from other substance abuse populations. They suggest that these differences may mean that residentially-based treatment for this group may be more effective compared to less expensive alternatives than that for other substance abuse populations. Further, they believe that such services need to be provided in institutional settings that are larger than those that Medicaid currently can support.

A new Department initiative will explore some of these issues. In September 1991, HCFA selected five demonstration projects designed to improve access to treatment for Medicaid-eligible, pregnant substance abusers. Awards were made to the following States: Maryland, Massachusetts, New York, South Carolina, and Washington. The projects are expected to initiate service delivery in October 1992, and will provide an array of services for pregnant substance abusers over a 3-year period. Three of these projects--Massachusetts, New York, and Washington--will offer IMD services.

E. Summary

Research on the treatment of ADM disorders demonstrates that most forms of care produce positive results, and can often justify their expense through reduction of other health care or societal costs. However, they are not equally cost-effective. In the treatment of mental disorders, hospitalization is the most expensive form of care, but no more effective (on average) than alternative, community-based programs. Most assessments of alcohol treatment indicate that outpatient care is as effective as inpatient care, but costs as little as one-tenth as much. Drug treatment studies have not progressed as far, but existing evidence supports conclusions similar to those for alcohol treatment.

Taken together, cost-effectiveness research suggests that for mental disorders and alcohol disorders, and probably for drug disorders, inpatient care is used more frequently than it need be or should be. Additionally, this literature has not established that the type of treatment provided in IMDs is either more effective or more cost-effective than alternatives. Accordingly, it provides little or no support for a change in the IMD policy to expand such care.

CHAPTER VI

Use of Medicaid to Finance ADM Services

This chapter highlights the use of Medicaid to pay for care for people with ADM disorders. First, services available under Medicaid to support ADM care are outlined. Next, expenditures for ADM services are reviewed with an emphasis on the importance of Medicaid as a source of funding. Finally, ways are described in which States may use Medicaid to support alternative community-based ADM services.

A. Medicaid Services that Support ADM Care

Despite the IMD exclusion, Medicaid is an important source of funding for ADM care in most States. Many ADM services are provided outside of institutional settings. Additionally, many Medicaid recipients of such care are not chronically or seriously mentally ill. Wright and Buck (1991) found that 9-10 percent of the Medicaid recipients in California and Michigan in 1984 received at least one instance of an ADM service. Of these, only about one-quarter had a diagnosis of psychosis.

Mandatory Services

States provide ADM care both through mandatory and optional Medicaid services. Mandatory services that are relevant for treatment of ADM disorders include (CRS, 1988):

Inpatient hospital services - services available at general hospitals, including psychiatric units of general hospitals;

Outpatient hospital services - services available through outpatient departments of general hospitals or of psychiatric hospitals qualified to participate in Medicaid;

Rural health clinic (RHC) services - services at special clinics in rural areas in States permitting RHCs;

Early and periodic screening, diagnosis, and treatment (EPSDT) services - regularly scheduled screening examinations to determine the presence of developmental disorders or chronic conditions for enrollees under age 21;

Nursing Facility services - services in licensed nursing homes for people over age 21;

Home health services - care provided in the home, including part-time nursing, services of a home health aide, and medical supplies and equipment used in the home; and at least one of the following optional home services: physical therapy, occupational therapy, speech pathology, and audiology services for individuals over age 21;

Physician services - services of physicians, including psychiatrists.

Optional Services

Optional services allow States to tailor their Medicaid programs to meet specific State objectives. States have chosen to use coverage for optional services in varied ways to support ADM services. Twelve optional services are particularly relevant to the needs of people with ADM disorders. Table 6.1 lists these services by State and specifies if they were available to both categorically and medically needy recipients in 1989.

In constructing Table 6.1, data for 1989 were not available on whether Medicaid coverage for nonphysician providers or for clinic, rehabilitative, personal care, or case management services included care specific to treatment for ADM disorders. However, such data were available for MH services in 1985 (Koyanagi, 1985), and footnotes within each service category indicate if the State included features specific to MH care in that year. Also, a more limited study of 42 States in 1990 evaluated their use of Medicaid optional services to support MH treatment (NASMHPD, 1991). Little data are available at this time on the use of optional services to support chemical dependency treatment.

Licensed nonphysician practitioners such as psychologists and psychiatric social workers can be covered and the Medicaid clinic option allows funding of outpatient psychiatric clinics. About three-fifths (31) of the States covered day treatment/partial hospitalization for psychiatric disorders in 1985 at clinics. Half the States covered these services at general hospitals. Twenty-nine States reimbursed psychologists and 11 States reimbursed social workers for treating ADM disorders. Psychiatric personal care or rehabilitative services were covered by less than one-third of the States in 1985. Case management services for psychiatric disorders were provided by nine States in 1985.

In 1989, the most widely adopted optional services were prescription drugs, covered in all States, and transportation services, covered everywhere except the District of Columbia. Forty States offered care for elderly people (over age 65) provided in IMDs. Twenty-five States covered IMD services for the elderly in SNFs and 30 States made IMD services available for the elderly in ICFs. Inpatient psychiatric services for children and adolescents (under age 21) were covered by 38 States. Forty States covered care by nonphysician providers and 49 States offered clinic services in 1989. In addition, 27 States provided occupational therapy, 26 States paid for personal care services, and 30 States offered case management services.

In 1990, 50 percent or more of the States surveyed indicated that they used targeted case management, rehabilitative services, and home health care services to provide care to persons with mental illness (NASMHPD, 1991). Half or more also used the clinic services option to support MH partial hospitalization and day treatment services. Smaller percentages also used personal care and outpatient hospital services for such care.

Although Medicaid cannot pay for services provided to IMD patients between ages 21 and 65, it does pay for a substantial percentage of people with ADM disorders in nursing homes that are not IMDs (see Chapter IV). In 1985, about 50,000 individuals (29 percent) under age 65 in nursing homes had a primary ADM diagnosis. Medicaid paid for care for nearly 24,000 (47 percent) of these (CRS, 1988).

Additionally, States may provide home and community-based waiver services to individuals who would otherwise be institutionalized. These services are designed to maintain persons in their communities. They may include those, such as respite care or psychosocial rehabilitation, that are not normally available under the Medicaid program or to other enrollees within the State. The number of individuals with ADM disorders who are currently served under home and community-based waiver programs is unknown. However, an indirect effect of the changes instituted by OBRA 87 and 90 was to allow these services to be offered to such individuals between ages 21 and 65 who would otherwise be placed in a nursing home.

B. Medicaid Expenditures for ADM Services

As shown in Table 6.2, direct expenditures from all sources for ADM care were estimated nationally to be $51.4 billion in 1985 (Rice, Kelamn, Miller, and Dunmeyer, 1990). Almost five-sixths of these expenditures represented care for people with mental illnesses. Another 13 percent was for treatment of people who abuse alcohol, with 4 percent for drug abuse treatment. More than half of direct ADM expenditures were financed by government (Rice et al., 1990), split about evenly between the Federal government, and State and local government (see Table 6.3). Private sources, including private health insurance, philanthropy, and patient out-of-pocket payments, contributed the remainder.

Table 6.4 shows that in 1985 the Federal government financed $1.2 billion or 14.5 percent of total revenues for mental health services administered through the primary mental health agency in each State (NIMH, 1987). Federal sources of funds represent a higher percentage of total funds for chemical dependency treatment programs administered through the State alcohol/drug agency than for MH programs administered by the primary MH agency. For example, in 1989, Federal revenues contributed 26.7 percent of the $2.4 billion in expenditures on chemical dependency programs through State alcohol/drug agencies in 1989 (Butynski, Canova, and Reda, 1989; see Table 6.5).

Despite the limitations imposed by the IMD exclusion, Medicaid constitutes an important source of Federal support of ADM services. Of the Federal funds supporting State MH agency programs, the majority (58.2 percent) were from Medicaid (see Table 6.4). In contrast, the Alcohol/Drug Abuse Block Grant (ADABG) was the primary source of Federal funds for State alcohol/drug agencies in 1989 (see Table 6.5). The ADABG (now the Alcohol, Drug Abuse, and Mental Health Block Grant) provided almost 20 percent of expenditures for State alcohol/drug agencies with another 7 percent from other Federal sources (Butynski et al., 1989).

Medicaid represented an estimated 12 percent of expenditures for ADM services at specialty MH organizations in 1986 (see Table 6.6). Almost one-third of these $2 billion in total Medicaid expenditures was for care at State and county mental hospitals. About 16 percent was for care at private psychiatric hospitals and another one-fourth was for care through multiservice mental health organizations.

In addition to supporting specialty psychiatric programs, Medicaid finances ADM services in the general medical sector. General hospitals, both with and without psychiatric units, are the major site of inpatient psychiatric care (see Chapter IV). NFs, physicians, and other general health professionals are also frequent providers of ADM care. These providers are particularly important for the Medicaid population since people with low socioeconomic status may be more likely to use a general health provider rather than a MH professional for ADM problems (Morlock, 1989). In particular, the emergency department of general hospitals has increased in importance as "the point of entry to professional help" for people with ADM disorders (Morlock, 1989). Medicaid enrollees use almost double the amount of MH services compared to the poor and near-poor without Medicaid coverage (Taube and Rupp, 1986).

Estimates of Total Medicaid ADM Expenditures

For several reasons, determining the exact amount of Medicaid spending for ADM services is very difficult. First, Medicaid Management Information System (MMIS) requirements do not ensure the accuracy of diagnostic information needed to identify recipients with ADM disorders. Second, in some States, necessary data is maintained in information subsystems outside of MMIS or the Medicaid agency's control. Most importantly, HCFA only collects some of the detailed claims level data that States maintain. Many States only submit summary information that does not allow any analysis of particular procedures or diagnostic groups. As a result of these constraints, estimates of Medicaid ADM spending must make inferences from special research studies, limited surveys, and/or other data sources.

Because estimates rely on different assumptions and data sources, they vary greatly. One recent effort suggested that 1983 Medicaid expenditures for MH services totaled $3.4 billion, or $1.6 billion exclusive of long term care (LTC) (Taube, 1990). Using a 5 percent inflation factor, these figures translate to $4.7 billion and $2.3 billion, respectively, in 1990. However, estimates based on actual ADM Medicaid expenditures indicate that the true amount may be two to three times as much. Using Medicaid

expenditure and utilization data from California and Michigan, Wright and Buck (1991) estimated 1984 national Medicaid expenditures for ADM services to be $3.5 to $4.9 billion, exclusive of LTC. Inflating these figures in the same manner as the Taube estimates suggests a range in 1990 dollars of $4.7 to $6.6 billion.

Given an overall level of Federal support of Medicaid expenditures of 56 percent, these figures suggest that Federal spending on Medicaid ADM services could range from $1.3 to $3.7 billion, exclusive of LTC. Including Federal spending for ADM LTC could add more than $1 billion to these amounts. Even the least of the estimates for non-LTC ADM Medicaid services exceeds the $1.2 billion that was spent through the Alcohol, Drug Abuse, and Mental Health Block Grant in FY 1990. The others suggest that Federal Medicaid spending on ADM services could be as much as four times that amount if LTC spending is included.

C. Use of Medicaid To Support Alternative ADM Services

Options available under Medicaid allow States to support many of the elements of ADM services that have been demonstrated to be cost-effective alternatives to inpatient care. This is most clearly the case for outpatient alcohol and drug treatment, which can be provided as clinic or rehabilitative services. In addition, other optional services, such as services of psychologists and psychiatric social workers, occupational therapy, personal care, transportation, and targeted case management, can be used to support such programs.

For individuals who are seriously mentally ill or those with more chronic chemical dependency problems, provision of alternative care requires a broad range of services. According to Stein and Test (1980), an alternative community-based program should include the following elements:

1. material resources, including food, shelter, clothing, and medical care;
2. "freedom from pathologically dependent relationships" including relationships with family members and mental health institutions;
3. support and education of community members in how to deal with patients;
4. development of coping skills to meet everyday needs;
5. support in solving real-life problems;
6. an assertive support system designed to "go to the patient" to insure continued care.

Most community-based treatment programs are designed to meet these requirements through a variety of funding sources. Optional and mandatory services under Medicaid can be used to fund services to meet many of these needs. Although the Stein and Test model was primarily developed to treat the seriously mentally ill, some States are adapting it for the treatment of those with chronic substance abuse problems.

Material Resources

People with ADM disorders living in the community must have basic survival needs met. These survival needs include food, shelter, and clothing. For ADM patients living with their families, these survival needs are usually met at home. In contrast, patients without family ties may require public support to meet their basic needs. In both cases, Medicaid funds necessary medical care.

Since Medicaid is designed as a medical rather than a social services program, States must use other sources of funds to provide food, shelter, and clothing for indigent people with ADM disorders in the community. The sources of funding for basic survival needs vary among States. Typical sources include the Federal Food Stamp Program for food, and State or locally funded residential care (often called board and care facilities or county homes) for shelter. Most poor chronically mentally ill individuals qualify for SSI or Social Security Disability Income (SSDI). Other Medicaid recipients with ADM disorders receive income maintenance through Aid To Families With Dependent Children.

Freedom From Harmful Dependent Relationships

Some chronic psychiatric patients need help in living independently. Interaction with family members often helps people with chronic ADM disorders. However, the ability of patients to cope with daily life may improve if the patient lives apart from family members. Similarly, for patients who rely on psychiatric institutions for a protected environment, provision of a supportive but independent living arrangement may improve social and psychological adjustment.

Since Medicaid is a medical program, reimbursement for room and board is beyond the scope of the program, with the exception of hospitals, nursing facilities, and residential psychiatric facilities for those under age 21. Therefore, States and localities must meet needs for most residential services through other programs. For many people disabled by chronic ADM disorders, SSI and SSDI income payments can be used to pay rent. In addition, many people with chronic ADM disorders qualify for Federal section VIII low income housing assistance. Finally, many States and localities offer residential care at State or locally funded board and care facilities or county homes.

It is in this area that the provisions of the IMD exclusion are particularly relevant. Some alternative programs include residential components with professional staffing. If these facilities exceed 16 beds, then they would qualify as IMDs and services provided to their Medicaid residents under age 65 would not be eligible for FFP. However, States have several options to avoid such an outcome and retain Federal Medicaid funding. First, individuals receiving community-based services in their homes or individual apartments would not be subject to such restrictions. Second, other residential settings, regardless of size, would also not be subject to IMD designation so long as diagnosis, treatment, or care were not provided in them. Finally, and most importantly, the limitation of the IMD definition to facilities of 17 beds or more means

that States may create smaller settings with on-site professional services without fear that they may be designated as IMDs. Smaller facilities may also be more compatible with general program goals of community integration and providing services in the least restrictive setting.

Another important aspect of independent living is employment. Although many people with chronic ADM disorders may initially be too disabled to work, vocational training and counseling can often make it possible for psychiatrically disabled people to obtain jobs. The Vocational Rehabilitation program, funded jointly by the Federal and State governments, provides job training, counseling, and other services designed to help disabled people find and maintain competitive employment. For people too disabled to work in regular jobs, many States provide opportunities for part-time or reduced wage jobs in sheltered workshops. Since employment assistance is not a medical service, Medicaid funds are not available to pay for vocational assistance for people with ADM disorders. However, Medicaid can be used to support "prevocational" training in areas such as problem solving, attending, and other general job-related skills.

Support and Education of Community Members

Stein and Test contend that it is important for the family, friends, and colleagues of people with ADM disorders in the community to understand the behaviors associated with psychiatric disorders. If they do, they can often provide emotional support to help clients cope outside institutions. While all such services would not be coverable under Medicaid, counseling provided to a patient's immediate family could be included as part of clinic or other services.

Coping Skills, Problem Solving, and Assertive Support

Meeting the last three requirements of the Stein and Test model generally requires ADM professionals to interact with patients in their home, work, and social environments. Various Medicaid optional services can be used to provide professional staff support for patients. For example, case management services targeted to people with chronic ADM disorders can help to identify and obtain services to help them cope with daily life. Interaction with patients at home to teach daily living skills can be provided through home health or personal care optional services. Since Medicaid allows reimbursement for care by nonphysician practitioners licensed by State law, the services of psychologists, social workers, and other licensed ADM professionals can be covered under Medicaid.

Teaching coping and daily living skills also is often a component of ADM day treatment and psychosocial rehabilitation programs. Day treatment or partial hospitalization in clinics or general hospitals can be covered as optional clinic or rehabilitative services under Medicaid, or as part of mandatory outpatient hospital services.

D. Summary

Medicaid is an important source of financing for ADM care for poor and disabled people. Among the mandatory Medicaid services particularly relevant for ADM care are inpatient hospital services, including psychiatric units of general hospitals; outpatient hospital services, including psychiatric care; EPSDT services; and physician services, including care by psychiatrists. Applicable optional services include prescription drugs, clinic services, non-physician providers, rehabilitative services, inpatient psychiatric services for individuals under age 21, case management services, occupational therapy, personal care services, and services in IMDs for those age 65 or over.

Estimates of Medicaid expenditures for ADM services vary widely, due to limited national data on the program. Despite this limitation, estimates suggest that such expenditures in 1990 may have been as much as $6.6 billion, exclusive of long term care. Medicaid expenditures for individuals with ADM disorders in nursing homes may have added more than $2 billion to these figures. The Federal share of even the lowest estimates exceeds that which was paid for ADM services under the Alcohol, Drug Abuse, and Mental Health Block Grant in 1990.

Medicaid funds can be used by States to support community-based treatment programs of the types that have been demonstrated to be cost-effective alternatives to ADM inpatient care. These funds can finance most of the medical, psychological, and other professional services considered necessary for such programs. Combined with other Federal, State, and local programs, Medicaid can be an integral component of less restrictive, community-based ADM treatment.

Table 6.1

OPTIONAL SERVICES IN STATE MEDICAID PROGRAMS, 1985 and 1989

State	Other Practitioner's Services	Clinic Services	Occupational Therapy	Prescribed Drugs	Rehabilitation Services	IMD Services For >=Age 65: Inpatient Hospital	IMD Services For >=Age 65: SNF Services	IMD Services For >=Age 65: ICF Services	Inpatient Psychiatric Services For <Age 21	Personal Care Services	Transportation Services	Case Management Services	Number Of Optional Services Covered
Alabama		C		C			C	C	C		C	C	16
Alaska		C 4	C	C					C	C	C		17
Arizona		C	C	C						C	C		14
Arkansas	C, M	C, M 3 4	C, M	C, M	C, M 6	C, M	C	C	C, M	C	C, M	C, M	24
California	C, M 1	C, M 3	C, M	C, M	C, M	C, M	C, M	C, M	C, M		C, M	C, M	22
Colorado	C 1 2	C 3 4		C		C	C	C	C	7	C	C 8	23
Connecticut	C, M 1 2	C, M 3 4		C, M	C, M	C, M	C, M	C, M	C, M		C, M		22
Delaware	C	C 3		C	C	C		C			C		17
D.C.	C, M 1	C, M 4	C, M	C, M	C, M	C, M	C, M	C, M	C, M	C, M 7			22
Florida	C, M	C, M		C, M	C, M 6	C				7	C, M	C, M	18
Georgia	C, M 1	C, M 3 4		C, M							C, M	C, M 8	17
Hawaii	C, M 1	C, M	C, M	C, M	C, M				C, M		C, M		17
Idaho	C 1 2	C		C	C 6			C			C		18
Illinois	C, M 1	C, M 3 4	C, M	C, M	C, M	C, M	C, M	C, M	C, M		C, M		22
Indiana	C 1	C	C	C	C	C			C		C		18
Iowa	C, M 1	C, M	C, M	C, M	C	C			C	C	C, M		19
Kansas	C, M 1 2	C, M 3	C, M	C, M	C, M	C, M		C, M	C, M	C, M 7	C, M	C, M	24
Kentucky	C, M 1 2	C, M 3	C, M	C, M	C, M	C, M	C, M	C, M	C, M	7	C, M	C, M	24
Louisiana	C	C, M 3 4		C, M	C, M	C			C		C, M	C, M	19
Maine	C, M 1 2	4	C, M	C, M	C, M 6	C, M			C, M	C, M 7	C, M	C, M	23
Maryland		C, M 3 4		C, M					C, M	C, M 7	C, M	C, M	18
Massachusetts	C, M 1 2	C, M 3 4	C, M	C, M	C, M	C, M	C, M	C, M	C, M	C, M	C, M	C, M	25
Michigan	C, M	C, M 3 4	C, M	C, M	C, M	C, M	C, M	C, M	C, M	C, M 7	C, M	C, M	24
Minnesota	C, M 1	C, M 4	C, M	C, M	C, M	C, M	C, M	C, M	C, M	C, M 7	C, M	C, M	24
Mississippi	C	C 4		C	C						C	C	16
Missouri		C 3		C	C	C			C	C	C	C	18
Montana	C, M 1 2	C, M 3	C, M	C, M	C, M	C, M	C, M	C, M	C, M	C, M	C, M		23
Nebraska	C, M	C, M 3		C, M		C, M	C, M	C, M	C, M	C, M	C, M	C, M	20

C: Categorically Needy: individuals receiving federally-supported financial assistance.
M: Medically Needy: individuals who are eligible for medical but not for financial assistance.

1: Medicaid covered psychologists in 1985.
2: Medicaid covered social workers in 1985.
3: Medicaid covered day treatment/partial hospitalization at clinics in 1985.
4: Medicaid covered day treatment/partial hospitalization at general hospitals in 1985.
5: All States with Medicaid drug coverage in 1985 covered psychiatric drugs.
6: Medicaid covered rehabilitation services for people with mental disorders in 1985.
7: Medicaid covered mental health personal care services in 1985.
8: Medicaid covered mental health case management services in 1985.

OPTIONAL SERVICES IN STATE MEDICAID PROGRAMS, 1985 and 1989 (Cont'd)

State	Other Practitioner's Services	Clinic Services	Occupational Therapy	Prescribed Drugs	Rehabilitation Services	IMD Services For >=Age 65: Inpatient Hospital	IMD Services For >=Age 65: SNF Services	IMD Services For >=Age 65: ICF Services	Inpatient Psychiatric Services For <Age 21	Personal Care Services	Transportation Services	Case Management Services	Number Of Optional Services Covered
Nevada	C 1	C 3	C	C	C	C	C	C		C	C		21
New Hampshire	C, M 1	C, M 3	C, M	C, M	C, M 6	C, M		C, M		C, M	C, M	C, M 8	22
New Jersey	C, M 1	C, M 4	C, M	C, M	C, M	C	C	C	C	C, M 7	C, M		23
New Mexico	C 1	C		C	C						C		15
New York	C, M 1	C, M 3 4	C, M	C, M	C, M 6	C, M			C, M	C, M 7	C, M	C, M	24
North Carolina		C, M 3 4		C, M	C, M 6	C, M			C, M	C, M	C, M		19
North Dakota		C, M 3 4	C, M	C, M	C, M	C, M			C, M		C, M		18
Ohio	C 1	C 3 4	C	C	C 6	C	C	C	C		C	C 8	24
Oklahoma	C, M 1	C, M 3 4		C, M	C, M	C			C, M	C, M	C, M	C, M	21
Oregon	C, M 2	C, M 4	C, M	C, M	C, M 6	C			C	C, M	C, M		21
Pennsylvania		C, M 3 4		C		C, M	C, M	C, M	C, M		C, M	C, M	19
Rhode Island		4		C, M	C, M 6	C, M	C, M	C, M	C, M	7	C, M	C, M 8	20
South Carolina	C	C 3		C	C 6	C	C	C	C	7	C	8	21
South Dakota	1	C 3 4		C	6		C	C		C 7	C		20
Tennessee	C, M	C, M 3		C, M		C	C	C, M	C, M		C, M		18
Texas	C, M 1	C, M		C, M	C, M					C, M	C, M	C, M	17
Utah	C, M 1	C, M 3		C, M	C, M	C, M	C, M	C	C, M	C, M 7	C, M	C, M	23
Vermont	C, M 1	C, M 3	C, M	C, M	C, M 6	C, M		C, M	C, M		C, M	C, M 8	22
Virginia	C, M 1 2	C, M	C, M	C, M	C, M	C, M	C, M	C, M			C, M	C, M	21
Washington	C, M	C, M 3 4	C, M	C, M	C, M	C, M	C, M	C, M	C, M		C, M	C, M 8	22
West Virginia	C, M	C, M 3		C, M					C, M	C, M 7	C, M	C, M 8	18
Wisconsin	C 1 2	C, M	C, M	C, M	C 6	C	C, M	C, M	C	C, M	C, M	C	24
Wyoming		C		C	C	C					C		14
CN	11	15	5	16	12	17	9	11	12	7	15	6	
CN and MN	29	34	22	35	28	23	16	19	26	19	35	24	
Total	40	49	27	51	40	40	25	30	38	26	50	30	

Average Number Of Optional Services Covered 20.62

C: Categorically Needy: individuals receiving federally-supported financial assistance.
M: Medically Needy: individuals who are eligible for medical but not for financial assistance.

1: Medicaid covered psychologists in 1985.
2: Medicaid covered social workers in 1985.
3: Medicaid covered day treatment/partial hospitalization at clinics in 1985.
4: Medicaid covered day treatment/partial hospitalization at general hospitals in 1985.
5: All States with Medicaid drug coverage in 1985 covered psychiatric drugs.
6: Medicaid covered rehabilitation services for people with mental disorders in 1985.
7: Medicaid covered mental health personal care services in 1985.
8: Medicaid covered mental health case management services in 1985.

Sources: Solloway, M. R. (1990). Major changes in State Medicaid and indigent care programs, 1989. Intergovernmental Health Policy Project, The George Washington University, January, 1990. (p. 4-5); Koyanagi, C. (1988). Operation Help: A mental health advocate's guide to Medicaid. National Mental Health Association.

Table 6.2

DIRECT COSTS OF ALCOHOL, DRUG ABUSE, AND MENTAL DISORDERS
BY TREATMENT SETTING, 1985

Category Of Costs	Expenditures (Millions Of Dollars) Total	Alcohol Abuse	Drug Abuse	Mental Disorders	% Of Total Treatment & Support Costs Total	Alcohol Abuse	Drug Abuse	Mental Disorders
ADM Specialty And Federal Institutions:	$15,682	$2,281	$570	$12,831	30.50%	4.44%	1.11%	24.95%
Federal Providers	$2,273	$664	$176	$1,433	4.42%	1.29%	0.34%	2.79%
State & County Psychiatric Hospitals	$5,661	$215	$91	$5,355	11.01%	0.42%	0.18%	10.41%
Private Psychiatric Hospitals	$1,888	$72	$30	$1,786	3.67%	0.14%	0.06%	3.47%
Other ADM Institutions	$5,860	$1,330	$273	$4,257	11.40%	2.59%	0.53%	8.28%
Short-Stay Hospitals	$13,064	$3,017	$1,242	$8,805	25.41%	5.87%	2.42%	17.12%
Other Treatment Costs:	$18,739	$1,017	$69	$17,653	36.44%	1.98%	0.13%	34.33%
Office-Based Physicians	$2,344	$141	$52	$2,151	4.56%	0.27%	0.10%	4.18%
Other Professional Services	$3,656	$173	$17	$3,466	7.11%	0.34%	0.03%	6.74%
Nursing Homes	$11,286	$703		$10,583	21.95%	1.37%	0.00%	20.58%
Drugs	$1,453			$1,453	2.83%	0.00%	0.00%	2.83%
Support Costs	$3,935	$495	$201	$3,239	7.65%	0.96%	0.39%	6.30%
Total Treatment Costs	$47,485	$6,315	$1,881	$39,289	92.35%	12.28%	3.66%	76.41%
Total Treatment and Support Costs	$51,420	$6,810	$2,082	$42,528	100.00%	13.24%	4.05%	82.71%

Note: Treatment costs are costs of medical and mental health care services for patients with alcohol, drug abuse, and mental disorders. Support costs include expenditures for research, program administration, training of health professionals, and the net cost of private health insurance.

Source: Rice, D. P., Kelman, S., Miller, L. S., & Dunmeyer, S. (1990). The Economic Costs of Alcohol and Drug Abuse and Mental Illness. Report submitted to the Office of Financing and Coverage Policy of the Alcohol, Drug Abuse, and Mental Health Administration, U.S. Department of Health and Human Services. San Francisco: Institute for Health & Aging, University of California, 1990, p. 8.

Table 6.3

DIRECT COSTS OF ALCOHOL, DRUG ABUSE, AND MENTAL DISORDERS
BY TREATMENT SETTING AND SOURCE OF PAYMENT, 1985

Category Of Costs	Expenditures (Millions Of Dollars) Total	Federal	State & Local	Private	% Of Total Treatment & Support Costs Total	Federal	State & Local	Private
ADM Specialty And Federal Institutions:	$15,682	$4,229	$9,520	$1,933	30.50%	8.22%	18.51%	3.76%
Federal Providers	$2,273	$2,273			4.42%	4.42%	0.00%	0.00%
State & County Psychiatric Hospitals	$5,661	$821	$4,585	$255	11.01%	1.60%	8.92%	0.50%
Private Psychiatric Hospitals	$1,888	$285	$189	$1,414	3.67%	0.55%	0.37%	2.75%
Other ADM Institutions	$5,860	$850	$4,746	$264	11.40%	1.65%	9.23%	0.51%
Short-Stay Hospitals	$13,064	$5,304	$2,123	$5,637	25.41%	10.32%	4.13%	10.96%
Other Treatment Costs:	$18,739	$3,584	$2,631	$12,524	36.44%	6.97%	5.12%	24.36%
Office-Based Physicians	$2,344	$165	$59	$2,120	4.56%	0.32%	0.11%	4.12%
Other Professional Services	$3,656	$256	$91	$3,309	7.11%	0.50%	0.18%	6.44%
Nursing Homes	$11,286	$3,092	$2,404	$5,790	21.95%	6.01%	4.68%	11.26%
Drugs	$1,453	$71	$77	$1,305	2.83%	0.14%	0.15%	2.54%
Support Costs	$3,935	$1,248	$302	$2,385	7.65%	2.43%	0.59%	4.64%
Total Treatment Costs	$47,485	$13,117	$14,274	$20,094	92.35%	25.51%	27.76%	39.08%
Total Treatment and Support Costs	$51,420	$14,365	$14,576	$22,479	100.00%	27.94%	28.35%	43.72%

Note: Treatment costs are costs of medical and mental health care services for patients with alcohol, drug abuse, and mental disorders. Support costs include expenditures for research, program administration, training of health professionals, and the net cost of private health insurance.

Source: Rice, D. P., Kelman, S., Miller, L. S., & Dunmeyer, S. (1990). The Economic Costs of Alcohol and Drug Abuse and Mental Illness. Report submitted to the Office of Financing and Coverage Policy of the Alcohol, Drug Abuse, and Mental Health Administration, U.S. Department of Health and Human Services. San Francisco: Institute for Health & Aging, University of California, 1990, p. 18.

Table 6.4

FEDERAL REVENUES FOR SERVICES OF THE PRIMARY
MENTAL HEALTH AGENCY IN EACH STATE, BY SOURCE, 1985

Source of Federal Revenue	Revenues	Percent
Medicaid	$710,287,549	58.2%
Alcohol, Drug Abuse, and Mental Health Block Grants	249,093,597	20.4
Medicare	181,384,361	14.9
Social Services Block Grants	51,079,250	4.2
Special Education	5,810,724	0.5
Other Alcohol, Drug Abuse, Mental Health	2,799,775	0.2
Other	18,657,671	1.6
Total	$1,219,459,455	100.0%

Note: Does not include revenues for alcoholism, drug abuse, or developmental disabilities programs.

Source: National Institute of Mental Health. (1987). Mental Health, United States, 1987. Manderscheid, R. W., and Barrett, S. A., Eds. DHHS Pub. No. (ADM)87-1518. Washington, DC: U.S. Government Printing Office, pp. 172-173.

Table 6.5

EXPENDITURES BY FUNDING SOURCE FOR STATE-SUPPORTED
ALCOHOL AND DRUG ABUSE SERVICES, 1989

Source Of Funds	Amount ($)	% Of Total
State	$1,137,705,382	47.1%
State Alcohol/Drug Agency	1,009,099,083	41.8
Other State Agency	128,606,299	5.3
Federal	644,535,967	26.7
Alcohol/Drug Abuse Block Grant	474,677,106	19.7
Other Federal Government	169,858,861	7.0
County or Local Agencies	191,799,581	7.9
Other Sources	440,130,907	18.2
Total	$2,414,171,837	100.0%

Note: Data are only from programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's Fiscal Year (1989).

Source: Butynski, W., Canova, D., & Reda, J. L. (1990). State resources and services related to alcohol and other drug abuse problems, Fiscal Year 1989: An analysis of state alcohol and drug abuse profile data. Washington, DC: National Association of State Alcohol and Drug Abuse Directors, p.8.

Table 6.6

ESTIMATED MEDICAID EXPENDITURES AT MENTAL HEALTH ORGANIZATIONS, 1986

Type Of Organization	1986 Expenditures In Current Dollars (000)	Assumed Percent Medicaid	1986 Estimated Medicaid Expenditures (000)	% Of 1986 Medicaid Expenditures
State and county mental hospitals	$ 6,325,844	10.00%	$632,584	30.26%
Private psychiatric hospitals:	$ 2,629,009		$343,315	16.42%
For-profit	$ 1,701,204	12.00%	$204,144	9.76%
Not-for-profit	$927,805	15.00%	$139,171	6.66%
Non-federal general hospital separate psychiatric services	$ 2,877,739	13.50%	$388,495	18.58%
RTCs for emotionally disturbed children	$977,616	13.50%	$131,978	6.31%
Freestanding psychiatric outpatient clinics	$518,069	13.67%	$70,820	3.39%
Freestanding psychiatric partial care organizations	$67,929	15.33%	$10,414	0.50%
Multiservice mental health organizations	$ 3,723,592	13.78%	$513,111	24.54%
Total	$17,119,798		$2,090,717	100.00%
Estimated Medicaid expenditures as a % of total expenditures				12.21%

Notes: Assumed Medicaid percentages are calculated from the "1986 Inventory Of Mental Health Organizations." Data exclude expenditures from Veterans Administration (VA) facilities.

Source: Redick, R. W., Stroup, A., Witkin, M. J., Atay, J. E., & Manderscheid, R. W. (1989, October) "Private Psychiatric Hospitals, United States: 1983-84 and 1986." U.S. Dept. Of Health and Human Services, Mental Health Statistical Note 191, p. 11.

CHAPTER VII

Cost Estimates of Eliminating the IMD Exclusion

This chapter estimates the amount of increased Medicaid expenditures that would result from eliminating the IMD exclusion. This policy change would have two specific types of impacts on a targeted set of providers. First, costs would be shifted to Medicaid for the treatment of eligible ADM patients whose care is not now paid for by the program. In addition to those in specialty ADM facilities, some of these patients reside in NFs that previously participated in the Medicaid program, but that were determined to be IMDs and removed. Second, demand for care would expand because elimination of the IMD policy would increase the number of residential beds available for Medicaid patients for ADM treatment.

A. Method

Estimates were based on data from the most current relevant studies available at the time the analysis was completed. Much of these data were from the mid-1980's, however. They did not reflect possible subsequent expansions of inpatient drug treatment or recent increases in IMD expenditures resulting from disproportionate share payments (Intergovernmental Health Policy Project, 1991). As a result, estimates based on these figures probably understate the actual costs of eliminating the IMD exclusion.

Two other limitations tend to offset each other. The analysis does not estimate any possible substitution of IMD care for general hospital psychiatric care, which could reduce the total costs of eliminating the exclusion. However, it also does not determine the cost increase that would result from additional facilities that would be created if Medicaid funding were available for their support.

Effects of eliminating the IMD exclusion were examined for the following types of facilities: State and county mental hospitals, private psychiatric hospitals, NFs that are IMDs, and other residential ADM service providers (e.g., residential treatment centers). Baseline estimates of the costs of treating patients in these types of IMDs were calculated from the recent report on the costs of ADM disorders by Rice et al. (1990). Table 7.1 presents data on total expenditures in 1985 for State and county mental hospitals, private psychiatric hospitals, and other ADM residential programs, excluding NFs. For each type of setting the amount of expenditures that are accounted for by Federal, State, and other sources are listed. The estimation strategy was to 1) determine the number of persons that would be paid for by Medicaid in the absence of the IMD exclusion, 2) estimate the total costs in each type of facility, 3) estimate the increased demand for various facilities that would result from the elimination of the IMD policy, and 4) impose a short to medium run constraint that existing capacity would not expand.

B. Results

The largest part of the estimated expenditures stemming from elimination of the IMD exclusion is the shift of costs to Medicaid for eligible ADM patients whose care is not now paid for by Medicaid. To determine the size of this group, the population of ADM patients for whom the reported source of payment was either "self-pay" or "no charge" was first identified. A recent survey in Maryland found that this population was overwhelmingly uninsured and unable to pay their hospital bills (Maryland Health Services Cost Review Commission, 1988).

Additional data from the NIMH Inventory of Mental Health Facilities and the Client Sample Survey for 1986 indicated that 52 percent of clients in State mental hospitals, 4 percent in private psychiatric hospitals, and roughly 11 percent of patients in other ADM residential facilities fell into the self-pay/no charge category (NIMH, 1990). Clearly, not all clients who are classified as self-pay or no charge are potentially Medicaid eligible under existing criteria. A recent survey in Ohio psychiatric hospitals suggests that roughly 50 percent of residents of these facilities are Medicaid eligible (Robert Wood Johnson Foundation, 1990). Given the absence of similar data for any of the other types of facilities, this percentage was used for all of them. This resulted in an estimate of 26 percent of State and county mental hospital patients newly receiving Medicaid services if the IMD exclusion were to be eliminated. The corresponding percentages for private psychiatric hospitals and other ADM residential facilities were 2 percent and 5.5 percent, respectively.

These percentages were applied to data on the number of annual inpatient days estimated for each type of facility (NIMH, 1990; NASADAD, 1990). For State and county mental hospitals, the resulting number of annual inpatient days was calculated to be 39,075,440, based on the average daily inpatient census for those facilities (.26 x 365 x 107,056). A similar calculation yielded a total of 171,368 annual inpatient days in private psychiatric hospitals (.02 x 365 x 23,475).

For ADM residential facilities, inpatient days were calculated from data on annual numbers of cases and median length of stay (Butynski et al., 1990; Grazier, 1990; NIMH, 1990). For each residential facility type, figures on annual new cases were multiplied by the percentage estimated to be Medicaid-eligible (5.5 percent). These numbers were in turn multiplied by median length of stay data to arrive at an estimated annual number of inpatient days that would be paid for if the IMD policy were eliminated. The number of days was estimated to be 4,727,055 for alcohol residential facilities, 1,418,117 for drug facilities, and 1,889,264 for mental health facilities.

To calculate total costs in each setting, a per diem cost of $161 was used for State and county mental hospitals, based on the average expenditure per inpatient day in 1986 (NIMH, 1990). A figure of $500 for 1990 was used for private psychiatric hospitals (derived from private communications with a number of such facilities). For residential facilities, a per diem of $57.14 was calculated based on 1989 weekly cost data (Grazier, 1990). However, Medicaid does not reimburse the room and board costs of residential

facilities (except for psychiatric facilities for those under age 21). Therefore, it was assumed that residential facility treatment costs would be roughly 60 percent of the total per diem, for a reimbursable per diem of $34.28.

Multiplying each of the per diems by the associated number of inpatient days yielded estimated expenditure increases for each of the facility types. To combine and update these figures, they were inflated to 1990 dollars using the all-items consumer price index. That index was used instead of the medical components index since the growth in prices for State mental hospitals has been well under the rate of growth for all hospitals. Combining the updated estimates generated a total of $2.34 billion in increased 1990 expenditures, prior to adjustments for increased demand and nursing home expenditures (see Table 7.2).

Based on evidence in the literature, bed elasticities (percent change in quantity of admissions divided by percent change in available beds) of between 0.3 and 0.5 were used to calculate the possible demand increase that would result from the greater accessibility of residential services. No substitution of IMD care for general hospital psychiatric care was assumed. Data from the NDATUS survey (ADAMHA, 1986) and NIMH Inventory (NIMH, 1986) indicated an average capacity utilization of 83 percent for all ADM residential treatment settings. This yielded an estimated 5 percent increase in bed availability for Medicaid patients and an estimated $0.36 billion in new 1990 expenditures. This increased the total of $2.34 billion to $2.70 billion.

Survey data did not permit similar calculations of the amount of increased expenditures that would result from the reentry of NFs that were previously decertified from the Medicaid program due to their designation as IMDs. Further, data were only available from a few States on current expenditures for such facilities, and these did not reveal any clear pattern. Based on this very limited information, it was assumed that the increase from such facilities coming back into the program would amount to $400 million. Adding this amount resulted in a final total estimate of nearly $3.10 billion as the cost of eliminating the IMD exclusion (see Table 7.2).

C. State to Federal Cost Shift

Not all of the $3.10 billion increase would represent new spending since State and local governments fund much of the IMD services provided to Medicaid eligible individuals under the current exclusion. Given that the average Federal share of Medicaid expenditures in 1990 was 56 percent, approximately $1.73 billion of this amount would be increased Federal spending, with about $1.36 billion attributable to the States. To estimate State and local spending for the target group in the absence of eliminating the exclusion, it was assumed that such spending would account for the same proportion of estimated expenditures for the group by treatment setting in 1990 ($2.34 billion total) as in 1985 (from Table 7.1). For example, in the absence of eliminating the exclusion, costs for Medicaid-eligible individuals in State and county mental hospitals are estimated to be $1.96 billion (see Table 7.2). (The additional amount resulting from the estimated demand increase would not apply since this would only occur if the IMD

exclusion were eliminated.) From Table 7.1, 81 percent of this amount ($1.6 billion) would be estimated to be paid for by State and local governments (since 81 percent, or $4.58 billion of the total $5.66 billion of State and county mental hospital costs were attributable to State and local government in 1985).

Applying this methodology to estimated expenditures for the other treatment settings results in a total estimate of $1.83 billion that State and local governments spent in 1990 on Medicaid eligible individuals in IMDs under the current exclusion. Adding the (State) costs of nursing homes that are IMDs increases this figure to $2.23 billion. However, the estimated cost to State and local governments if the IMD exclusion were to be eliminated would be $1.36 billion (.44 x $3.10 billion). Therefore, the estimated net cost to such governments of eliminating the exclusion would be a decrease of $870 million in their expenditures.

D. Summary

Eliminating the IMD exclusion would be expensive. Conservative estimates suggest that this statutory change would increase total Medicaid expenditures by $3.10 billion, of which $1.73 billion would be the Federal cost and $1.36 billion the State and local cost. However, much of these increased expenditures would simply represent a substitution of Federal funding for State and local funding. State and local governments are estimated to save $870 million if the IMD exclusion were to be eliminated.

Table 7.1

ADM SERVICE EXPENDITURES BY TREATMENT SETTING, 1985
(In billions of dollars)

State and County Mental Hospitals	$5.66
Federal	.82
State and Local	4.58
Other	.26
Private Psychiatric Hospitals	$1.89
Federal	.29
State and Local	.19
Other	1.41
Other ADM Residential Settings (other than nursing homes)	$5.88
Federal	.85
State and Local	4.75
Other	.28

Source: Rice, D. P., Kelman, S., Miller, L. S., & Dunmeyer, S. (1990). The economic costs of alcohol and drug abuse and mental illness. Report submitted to the Office of Financing and Coverage Policy of the Alcohol, Drug Abuse, and Mental Health Administration, U.S. Department of Health and Human Services. San Francisco: Institute for Health & Aging, University of California, 1990.

Table 7.2

ESTIMATED INCREASES IN MEDICAID EXPENDITURES RESULTING FROM ELIMINATING THE IMD EXCLUSION
(In thousands of 1990 dollars)

Treatment Setting	Increased Expenditures	With Demand Increase
State and County Mental Hospitals	$1,962,838	$2,265,115
Private Psychiatric Hospitals	85,684	98,879
Other ADM Residential Settings		
Mental Health	67,613	78,025
Drug Abuse	50,752	58,568
Alcohol Abuse	169,173	195,226
Subtotal	$2,336,060	$2,695,813
Nursing Homes that are IMDs	N/A	400,000
Total	$2,336,060	$3,095,813

CHAPTER VIII

Discussion

Under section 6408 of OBRA 89 (P.L. 101-239), Congress required the Secretary of Health and Human Services to conduct this study of the IMD exclusion. The study has reviewed HCFA's implementation of the policy and related litigation, and discussed related policy issues. It has examined the changes that have occurred in the ADM service system since 1972, and reviewed the research literature on the cost-effectiveness of ADM services. Finally, it has described the relationship of Medicaid to the support of such care and estimated the costs of eliminating the exclusion.

A. Conclusions

No findings in this study support a recommendation for any statutory change in the IMD exclusion. The courts have found that HCFA's implementation of the policy has been reasonable and does not conflict with Congressional intent. While this intent is not completely clear, it appears likely that Congress wished States to continue their responsibility for ADM services that existed when the Medicaid program was created. From this perspective, the IMD exclusion represents the means by which the Federal government limits its support of ADM services within the Medicaid program. This interpretation is reinforced by the finding that much of the increased Medicaid expenditures that would result from eliminating the exclusion would simply refinance existing State and local ADM spending.

Changes that have occurred in ADM services mean that the exclusion has a smaller impact on the total ADM service system now than it did in 1972. First, perhaps partially in response to the policy, States have significantly reduced the number of MH beds that they directly operate. This also has reduced the proportion of MH inpatient care affected by the exclusion. Second, the increases in ADM outpatient and partial care mean that inpatient care is now a smaller part of the total ADM service system. Finally, changes in Medicaid law have both reduced the application of the exclusion and expanded Medicaid funding for other ADM services.

It may still reasonably be asked if the IMD exclusion creates incentives for inappropriate care or prohibits funding of necessary services. On one level, the answer to this question is negative. Although the exclusion limits support of some ADM inpatient care, the majority of such care can still be covered under the program (e.g., within general hospitals). Further, program options allow States to support services that are cost-effective alternatives to traditional psychiatric hospitalization. As a result, States can use Medicaid to help fund ADM service systems that provide a complete continuum of care and promote community-based services in the least restrictive setting.

Some question if the exclusion nevertheless encourages over or underutilization of certain types of facilities. This charge is most frequently made concerning nonhospital residential programs for substance abuse. Proponents of these programs argue that they are cheaper than traditional hospital care and that they are needed to treat more severe substance abuse problems. Although Medicaid can fund such services in smaller settings, they contend that larger programs also should be supported. Further, they propose that Medicaid be able to pay for the room and board costs of these settings.

Generally, research supports the contention that these programs are cost-effective alternatives to traditional psychiatric hospital programs. However, evidence also suggests that partial care and outpatient programs can produce equivalent outcomes at even less cost. Little or no data exist that establish that certain types of substance abusers do better in residential treatment programs compared to less expensive alternatives. Similarly, no research has established that larger institutional settings are superior to smaller ones. Accordingly, there does not appear to be an empirical basis for eliminating the IMD exclusion for this area, or for further expanding Medicaid services to pay for room and board costs in residential treatment programs.

Utilization of NFs by ADM patients is the other area in which critics have charged that the IMD exclusion has created incentives for inappropriate care. Historically, these settings have provided primarily custodial care for ADM patients, and few specialty services (Bootzin, Shadish, and McSweeney, 1989; Cicchinelli et al., 1981). Nursing home reforms instituted in OBRA 87 and 90 were partly meant to address this situation. NFs now must provide specialty psychiatric care if it is needed. Additionally, PASARR provisions require that individuals with serious mental illness be screened by the State's mental health authority prior to NF admission.

As described in Chapter III, the agency believes that the IMD policy implicitly expects that a State will provide necessary ADM services for its citizens. The PASARR process then serves as the means to identify those who require residential placement primarily for the treatment of mental illness and to direct them to appropriate alternative facilities. Nothing in the legislation or accompanying regulations necessarily ensures that this will happen, however. Therefore, the possibility remains that some States will continue to rely heavily on NFs as a site of care for Medicaid enrollees with ADM disorders. Because the IMD exclusion means that such individuals will remain a minority of the treatment population in such facilities, their care there may continue to be deficient.

A final issue concerns the relative merits of Medicaid versus the Alcohol, Drug Abuse, and Mental Health Block Grant as a vehicle for future changes in Federal ADM policy. The block grant allows targeting of specific services, providers, or patient subgroups to a greater degree than the Medicaid program. It also has the advantage of allowing services to continue to be funded despite possible changes in individuals' living circumstances that in the Medicaid program might cause a loss of eligibility and a subsequent termination of care. The block grant permits better control over Federal

expenditures. Finally, it provides greater incentives for States to set priorities in funding services, providers, or patients.

In contrast to the block grant, Medicaid supports all covered ADM services for its enrollees, regardless of individual cost. It also possibly provides greater access to care through allowing a wider range of providers to offer services. These differences between the two programs do not necessarily favor one over the other. However, they do suggest that the relative merits of the programs need to be weighed when determining how to pursue specific policy goals.

B. Related Issues

Although not part of the specific mandate for the report, several issues associated with the IMD policy were brought to the agency's attention in the course of its preparation. One of these concerns the alleged conflict between current State Medicaid Manual criteria for identifying an IMD and requirements for psychiatric care that NFs now must meet under changes initiated with OBRA 87 (see Chapter III). Some NFs are concerned that meeting the OBRA 87 requirements could increase the likelihood of their designation as IMDs. Another issue is the standards that the agency currently uses for identifying an institution. Under these guidelines, mergers between IMDs and other types of medical institutions may be occurring to avoid an IMD designation.

A final issue pertains to IMD patients who temporarily leave the IMD to receive non-ADM medical care in other settings (e.g., surgery in a general hospital). In such situations medical assistance is not available during the absence. It has been questioned if this policy affects the availability of non-ADM medical care for IMD patients or the likelihood of IMDs with limited medical services (e.g., residential treatment centers) admitting Medicaid eligible patients.

C. Services for Pregnant Substance Abusers

As Chapter V has described, current drug abuse treatment studies have not examined some important subpopulations. This is certainly true for pregnant substance abusers. Evidence for other subpopulations suggests that the IMD policy does not prevent Medicaid support of necessary or cost-effective services for chemically dependent pregnant women.

Nevertheless, the Department is concerned about services for this group and the lack of information in this area. Accordingly, a new initiative will examine alternative treatment approaches for this group, including IMD services. In September 1991, HCFA selected demonstration projects in five States designed to improve access to treatment for Medicaid-eligible, pregnant substance abusers. The projects are expected to begin in October 1992, and will provide an array of services over a 3-year period.

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Glossary of Terms

Additions (inpatient). Persons admitted or readmitted to inpatient services as well as those persons returned from long-term leave or transferred from noninpatient components of organizations. An addition is counted separately each time a person is admitted, readmitted, or returned from long-term leave during a year.

Additions (noninpatient). Persons admitted or readmitted to outpatient or partial care settings or transferred to one of these settings from another organization or another setting within the same organization during a year.

ADM. "Alcohol, drug abuse and mental health," used to refer to types of disorders or services.

Alcoholism hospital. An institution that provides 24-hour services for the diagnosis and treatment of alcoholic patients through an organized medical or professional staff and permanent facilities that include inpatient beds, medical and nursing services. Clients residing in this type of hospital setting should be receiving services primarily for alcoholism and/or other drugs of abuse.

CMHC. Community Mental Health Center. From 1972 to 1981, CMHCs were legal entities through which comprehensive mental health services were provided to a special geographic area. The CMHC could have been established by a single organization or by a group of affiliated organizations that made available five essential mental health services: (1) inpatient, (2) outpatient, (3) partial, (4) emergency care, and (5) consultation and education. Federal funds for CMHCs were provided under P.L. 88-164 (construction) and/or P.L. 89-105 (staffing) or the amendments thereto. Shifts in funding of CMHCs from categorical to block grants in 1981 caused the National Institute of Mental Health (NIMH) to reclassify CMHCs to multiservice organizations, freestanding psychiatric outpatient clinics, or psychiatric units of non-Federal general hospitals depending on the types of services they directly operated and controlled. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) continued to classify organizations as CMHCs based on the five types of service required for the classification.

DAB. Departmental Appeals Board.

DHHS. Department of Health and Human Services.

Episodes. The number of patients being treated at the beginning of the year plus all additions during the year.

EPSDT. Early and periodic screening, diagnosis, and treatment.

FFP. Federal financial participation.

Freestanding psychiatric outpatient clinic. An administratively distinct organization that is not part of another organization and whose primary purpose is to provide only ambulatory mental health services on either a regular or emergency basis.

Freestanding psychiatric partial care organization. An administratively distinct organization that is not part of another psychiatric organization and whose purpose is to provide programs/services for nonresidential patients who generally require more time (3 or more hours) than that provided through outpatient services, but who require less than 24 hours in the setting.

FSIIS. Field Staff Information and Instruction Series.

General hospital with separate psychiatric service(s). A licensed non-Federal general hospital or Veterans Administration (VA) medical center that admits patients to either (a) a separate psychiatric inpatient setting in which beds are specifically set up and staffed exclusively for psychiatric patients, and separated from regular medical or surgical beds, or (b) a separate psychiatric outpatient setting in which organized psychiatric services are provided in a separate hospital clinic established exclusively for the care of ambulatory psychiatric patients.

Halfway house. An organization that provides transitional living quarters and assistance in activities of daily living to previously hospitalized patients in preparation for returning to home or community environments.

HCFA. "Health Care Financing Administration," the Federal agency that administers the Medicaid program.

HDS. "Hospital Discharge Survey," conducted annually by the National Center for Health Statistics. Uses samples representative of the U.S. hospitalized population.

HPA. Handbook of Public Assistance.

ICF. Intermediate care facility.

IMD. Institution for Mental Diseases.

JCAH. "Joint Commission on Accreditation of Hospitals," now the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

LTC. Long term care.

MCCA. Medicare Catastrophic Coverage Act.

MH. Mental health.

MMIS. Medicaid Management Information System.

Multiservice mental health organization. An administratively distinct organization that provides inpatient or residential treatment, and any combination of outpatient and day treatment; in settings that are under the organization's direct and total control. Prior to 1983 organizations had to have inpatient/residential and outpatient treatment (with or without day treatment) to be classified as multiservice organizations. After this time, any two program elements (e.g., outpatient and partial care services) would qualify an organization as a multiservice one.

Many entities formally classified as CMHCs (whether formerly Federally funded or not) were classified as multiservice mental health organizations after 1980 depending upon the services offered and the administrative control of the CMHC. If the CMHC met the above criteria for a multiservice mental health organization and was not a part of a general or psychiatric hospital, it was classified as a multiservice mental health organization. If the CMHC met the above criteria for a multiservice mental health organization and was under the administration of a general hospital or a psychiatric hospital, it was classified as a general hospital with a separate psychiatric service or psychiatric hospital.

NCHS. National Center for Health Statistics.

NDATUS. "National Drug and Alcoholism Treatment Unit Survey," conducted in 1978, 1982, and 1987 jointly by the National Institutes on Drug Abuse, and Alcohol Abuse and Alcoholism.

NIAAA. National Institute on Alcohol Abuse and Alcoholism.

NIDA. National Institute on Drug Abuse.

NIMH. National Institute of Mental Health.

OBRA. Omnibus Budget Reconciliation Act.

OIG. Office of the Inspector General.

Other residential facility (NIDA & NIAAA). A live-in setting where nonmedical rehabilitative drug abuse and/or alcoholism services are available to residents in locations such as foster homes, group homes, or boarding houses. This designation is used when other types of residential facilities listed for the NDATUS surveys are not appropriate for classification.

Other specialized hospital. Includes hospitals that emphasize the diagnosis and treatment of particular disorders. This designation was used by the NDATUS surveys when the hospital was neither a general, psychiatric, alcohol, VA, or military hospital.

PASARR. Pre-Admission Screening and Annual Resident Review.

PMEs. Partial months of eligibility.

Residents. The number of patients in treatment in a particular facility on a given day.

RTC. A residential treatment center for emotionally disturbed children is a residential organization, not licensed as a psychiatric hospital, whose primary purpose is the provision of individually planned programs of mental health treatment services and residential care for children and youth primarily under the age of 18. The program must be directed by a psychiatrist, psychologist, social worker, or psychiatric nurse who has a master's and/or a doctorate degree.

SMM. State Medicaid Manual.

SNF. Skilled nursing facility. Medicaid no longer distinguishes between skilled and intermediate nursing care, but only refers to "nursing facility" services.

TCL. Training in Community Living.

TOPS. Treatment Outcome Prospective Study.

VA. Veterans Administration.

Appendix A

Chronology of Major Events Affecting the IMD Exclusion

1950 The Social Security Act Amendments of 1950 exclude from old age assistance, payments to or care in behalf of individuals in institutions for mental diseases (IMDs). The rationale contained in the committee report for this exclusion was that States generally provided for medical care of such cases.

1965 Medicaid is enacted with the Social Security Act Amendments of 1965. Availability of Federal financial participation (FFP) for services to persons age 65 or older in IMDs is established, contingent on States developing alternate methods of care. FFP is still excluded for services provided to persons under age 65 in IMDs. The rationale of State responsibility for such care is reiterated in the committee reports.

1966 The term "IMD" is defined in The Handbook of Public Assistance Administration as "an institution whose overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases."

1969 Formal regulations regarding the IMD exclusion are published.

1971 Congress amends the Medicaid statute to include coverage of ICF services. The IMD exclusion is not modified.

1972 Congress expands availability of FFP to inpatient psychiatric hospital services for individuals under age 21. FFP is also authorized for ICF services for the elderly in IMDs. The Conference Report explains that when a State chooses to cover individuals age 65 and over in IMDs it must cover such care in intermediate care facilities (ICFs) as well as in hospitals and skilled nursing facilities.

1975 The Social and Rehabilitation Service of DHEW 1976 issues Field Staff Information and Instruction Series to its regional commissioners alerting them to suspected improper claiming by States for FFP for the excluded age group in IMDs. The issuances first set forth the criteria by which the IMD status of a facility would be evaluated.

1978	The Health Care Financing Administration (HCFA) 1980 and the Office of the Inspector General (OIG) conduct reviews to identify IMDs, and disallowances are issued to California, Connecticut, Illinois, and Minnesota.
1981	The Departmental Appeals Board (DAB) issues Decision No. 231, upholding the HCFA disallowances in each of the four States.
1982	The District Court of Minnesota, in the Granville House v. Dept. of HHS litigation, finds the Secretary's classification of alcoholism and other forms of chemical dependency as mental diseases to be unreasonable.
1982	HCFA issues State Medicaid Manual (SMM) section 4390, updating the criteria for determining if a facility is an IMD.
1984	On remand from the Court of Appeals for the Eighth Circuit in the Granville House litigation, the DAB issues Decision No. 529, which orders HCFA to construct guidelines "which enable HCFA and its constituents to better evaluate what types of alcoholism treatment are, and are not, conclusive of IMD status."
1985	The "Partial Month of Eligibility" exception to the IMD exclusion is eliminated through regulatory revisions.
1985	The Supreme Court rules unanimously that HCFA's interpretation of the IMD exclusion is reasonable. It finds that an ICF or SNF may be an IMD and that the designation may be applied to both public and private facilities.
1986	HCFA revises SMM section 4390 to provide additional information concerning organic brain syndrome, drug and alcohol treatment facilities, and facility review methodology.
1987	The OIG initiates a nationwide review to identify IMDs.
1987	Congress enacts nursing home reform provisions in OBRA 87, and adds section 1905(i) to the Act, which requires that a facility have at least 17 beds to be considered an IMD.
1989	The DAB issues Decision No. 1042, holding that the emergency hospital services regulation does not waive the IMD exclusion. The Board also reiterates that Congressional intent clearly indicated that the exclusion covers short term acute care services as well as long term care.

Appendix B

Partial Months of Eligibility

Another source of controversy between the States and HCFA has been regulations which allowed Federal financial participation (FFP) for "partial months of eligibility" (PMEs) for individuals in IMDs. There have been 31 Departmental Appeals Board decisions dealing with this issue.

Regulations governing PMEs were based on the following statement in the legislative history of the 1965 amendments:

> "Medical assistance provided under the bill may include payment for care and services provided at any time within the month in which an individual becomes eligible or ineligible for assistance; e.g., by attaining a specified age. This avoids the administrative inconvenience of segregating bills by the day of the month on which care or services were provided and is consistent with the monthly pattern of benefits under the other public assistance titles." [S. Rep. No. 404]

The regulations promulgated in 1971 at 45 CFR 248.60 addressed this Congressional concern with the following provision: "[FFP] is available in the costs of medical assistance for the month in which an individual (if otherwise eligible) became. . . a patient in an [IMD]."

These provisions were later recodified at 42 CFR 435.1008(b) and 436.1004(b). However, effective May 3, 1985, HCFA eliminated the PME exception to the IMD exclusion. The rationale for this change was provided in the background statement accompanying the Final Rule amending section 435.1008 and section 436.1004: "When the . . . (pre-May 3, 1985) regulations were published, States generally did not have sophisticated claims processing systems. However, the situation has changed and most States now have a mechanized claims processing and information retrieval system which enables them to determine when noninstitutional services furnished to certain institutionalized individuals are no longer covered." Consistent with this reasoning, the new regulations at section 435.1008(b) and section 436.1004(b) now provide that "the exclusion of FFP [with respect to IMDs] does not apply during that part of the month in which the individual is not an inmate of a public institution or a patient in an [IMD].

Appendix C

Sources and Qualifications of the Data
on Service System Trends

Data included in this report were compiled from several sources, often with limited comparability. Data on the overall organized mental health system were compiled from reports by the National Institute of Mental Health (NIMH) on its national surveys and collaborative studies. These data are generally published every 2 to 3 years. They are based on representative samples of all patients treated in organized psychiatric facilities.

NIMH data include both long term (over 30 days) and short term hospitalizations, but no distinction between the two is made in the reports. Alcohol and drug disorders are included as diagnoses if they were treated in an organized psychiatric facility. For the period covered, patients who are treated in general hospitals with psychiatric units but are treated outside the unit are not included; nor are patients who are treated in general hospitals without units. Additionally, patients treated in chemical dependency units that are separate from the psychiatric unit are not included. However, such units that are part of (specialty) psychiatric hospitals or clinics are included.

The data are not strictly comparable between 1972-1980 and afterwards. In 1981, there was a shift in funding of the Community Mental Health Centers (CMHC) program from categorical to block grants. As a result, the category of "Federally funded CMHC" was dropped from 1981 onward. Organizations that were classified as CMHCs prior to 1981 were reclassified as multiservice mental health organizations, freestanding psychiatric outpatient clinics, or as psychiatric units of non-Federal general hospitals, depending on the types of services they directly operated and controlled (see Glossary of Terms). Additionally, changes in the classification criteria for outpatient care in 1983 resulted in many clinics being reclassified as multiservice facilities.

Data on alcohol and drug treatment were compiled from reports by the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism's of their National Drug and Alcoholism Treatment Unit Survey (NDATUS). These data were largely unavailable prior to 1977. The data are aggregate counts for alcohol or drug treatment units rather than client level data, so most patient level data (such as length of stay) are missing.

Estimates for the number of patients treated outside of the organized psychiatric or alcohol and drug treatment sites were calculated from the National Center for Health Statistics' Hospital Discharge Survey (HDS). This survey is conducted annually on a representative sample of discharges from non-Federal, short term hospitals, and are therefore limited in their accuracy. Hospitals are classified as long or short term based on the average length of stay of the patients. If the average is greater than 30 days the hospital is classified as long-term. These data do not include data on specialized

psychiatric and/or chemical dependency units or whether the patient was treated in such a unit.

Data specific to short term State and county mental hospitals and private psychiatric hospitals were compiled from the American Hospital Association's (AHA) Hospital Statistics. These data are published yearly, and include essentially all of the general hospitals in the United States. However, some mental and psychiatric hospitals are underrepresented. AHA data do not include patient or treatment information but do include estimates of the numbers of patients. These numbers of patients were used in calculations to remove overlap between the sources of data.

Nursing home data were compiled from the National Center for Health Statistics' (NCHS) reports on nursing and related care homes. These data have been collected periodically since 1969. The most recent year available for this report was 1985. Nursing home data were not limited to ADM disorders, although they did include primary diagnoses.

The data overlap across sources in several ways. Some facilities have units that treat both mental and chemical dependency disorders in the same unit setting. These combined units would appear in the NIMH reports as psychiatric units, while NDATUS would have called them alcohol, drug, or combined alcohol-drug units depending on whether alcohol, drug, or both types of disorders were treated there.

NIMH counts a facility at the administrative control or ownership level. For example, a hospital with two psychiatric units, one for adults and one for children, would be counted only once by NIMH. NDATUS counts units rather than the organizational entity so that a hospital with both an alcohol unit and a drug unit would have been counted as two facilities unless the two were combined into a single alcohol-drug unit. NDATUS reports alcohol and drug facilities separately but many, if not most, are units or facilities that treated both alcohol and drug disorders.

The two surveys also vary in the comprehensiveness of their utilization data. NIMH includes counts of the total number of residents on the first day of the year and added admissions or new patients throughout the year to arrive at an annual total. NDATUS only counts the number of residents on a single day of the year. Alcohol and drug disorders that were treated in psychiatric facilities are included in the MH subsection, but are not included in the chemical dependency subsection because NDATUS samples alcohol and/or drug treatment units. These inconsistencies make it impossible to determine how many of the MH episodes included in the MH subsection are also included in the ones for alcohol and drug treatment.

The discharges reported in the HDS data and NIMH's reported discharges also overlap to some extent. NIMH reports ADM discharges (both long and short term) in general hospital psychiatric units; HDS includes ADM discharges from short term general hospitals, both with and without units. NIMH reports discharges in State and county mental hospitals and private psychiatric hospitals, HDS includes discharges from these

two types of hospitals if they were classified as short term. The NDATUS surveys include all chemical dependency treatment facilities. Of these, any clients in treatment (shown on Tables 4.13 and 4.14) who were being treated in alcohol and/or drug units of short term general hospitals will duplicate the discharges shown in the HDS surveys.

For this report, an effort was made to remove the major duplications within a single table by subtracting the NIMH discharges from general hospital units and the estimates of short-term State and county mental hospital and short term private psychiatric hospitals from the total short term discharges reported by NCHS's HDS. The remainder after these subtractions represents a minimum number of patients treated outside the organized system of psychiatric care. This estimate is somewhat lower than the actual number because episodes, which include the number still in treatment, are subtracted from discharges. It was not possible to remove other duplications that occur across tables.

Appendix D

Trends within Mental Health Inpatient Sites

State Hospitals

From the mid-1960's on, State mental hospitals have accounted for a decreasing share of the total number of inpatients treated in the United States. The number of residents in State hospitals has fallen from 275,000 in 1972 to 111,000 in 1986. This was a continuation of the dramatic decreases that began in 1955 when the resident census peaked at 559,000. Admissions decreased from about 390,500 in 1972 to about 333,000 in 1986, but have generally fluctuated in the 300,000 to 350,000 range since the mid-1970's.

In the 1950's, there were three times as many residents as annual admissions; in the 1980's, one-third as many. Total days of care in State hospitals declined from 100 million in 1972 to about 39 million in 1986. Generally, days of care have decreased in State and Veterans Administration (VA) hospitals and increased in general hospitals and private psychiatric hospitals.

State and county mental hospitals have increasingly emphasized short term acute care. In 1972, only 6 percent of State mental hospitals met the criterion of the American Hospital Association (AHA) as a short term specialty hospital (average length of stay of less than 30 days for all cases). By 1985, 13 percent of the State and county mental hospitals met this criterion and were treating 18 percent of the inpatient episodes there. The average length of stay in these facilities declined from 160 days in 1972 to 88 in 1986. (These figures do not represent true length of stay, but rather that for an average case within a single year.)

The trends between 1972 and 1986 in State and county mental hospitals are primarily due to long term hospitals closing over the period. There are simply fewer of these facilities remaining, and they are treating fewer patients. These changes account for the decrease in admissions to public mental hospitals and for the decrease in inpatient episodes to facilities with an average length of stay greater than 30 days (mostly public mental hospitals). Other public mental hospitals have modified their mission to emphasize acute care, and some small, acute care facilities have been created. Nevertheless, public mental hospitals are, for the most part, still long term facilities, although the average length of stay in 1985 is shorter than it was in 1972.

VA Hospitals

The VA data are complicated because the VA operated both general medical and psychiatric facilities until 1979, although psychiatric patients were treated in both. However, total psychiatric inpatient episodes treated in VA facilities were fairly steady in the time period 1972-1983 at around 200,000. Like the State hospitals, the average

length of stay fell rather dramatically in that time period. Total days of psychiatric inpatient care in 1972 in VA facilities were over 11.5 million, and by 1986 had fallen to 7.8 million. The average length of stay for a "psychotic" patient (a VA classification) fell from 284 days in 1972 to 86 days in 1983, and the average length of stay for other psychiatric cases fell from 90 days to 31 days in the same time period.

Private Psychiatric Facilities

Episodes in private psychiatric facilities increased 80 percent between 1971-1981. The average length of stay varies by the for-profit status of the hospital. From 1971 on, the average length of stay (in days) in for-profit hospitals averaged in the low to mid-30's on an annual basis and was stable. In not-for-profit hospitals, the average length of stay fluctuated more, but gradually decreased to the low 40's. In 1972, about 53 percent of all private mental hospitals were classified as long term, and those hospitals admitted about 36 percent of all private mental hospital patients. By 1985, only 39 percent of all private mental hospitals were classified as long term. Between 1972 and 1985 the number of private mental hospitals increased by 93 percent (from 181 to 350). The increase was much greater for short term private hospitals (149 percent) than long term hospitals (44 percent). The "decrease" in patients admitted to private long term facilities is due entirely to the increase in the number of short term facilities and patients. The actual number of patients treated in long term private mental hospitals increased by 83 percent during that period while the number of patients treated in short term private hospitals increased by 174 percent.

Community Mental Health Centers

Since the Omnibus Budget Reconciliation Act of 1981, which created the block grant program, data on Community Mental Health Centers (CMHCs) have been difficult to obtain. CMHCs are no longer directly funded by the Federal Government. For the time period 1972-1981, inpatient episodes in CMHCs increased from 130,088 to 254,288. During that time period, the average length of stay gradually decreased from over 17 to around 14 days.

General Hospitals

Identifying psychiatric inpatient care in general hospitals is difficult. NIMH has routinely surveyed care in psychiatric units since the 1950's. The number of episodes treated in psychiatric units increased gradually from 1972 to 1984 from about 540,000 to 883,000. However, many general hospital patients with a primary diagnosis of mental disorder are not treated in a psychiatric unit. Some patients are treated in a chemical dependency unit. Others are treated in hospitals with specialized units, but outside the unit.

The non-Federal, short term general hospital without any specialized ADM units has become an important source of psychiatric inpatient service. These "scatter" hospitals have been a fairly recent phenomenon in treating mental disorders. Kiesler and

Sibulkin (1987) found 184,000 episodes treated outside psychiatric units in 1965. In 1972 this number had increased to about 507,000. In 1985, there were still over 840,000 episodes of ADM inpatient care in general hospitals, but outside of psychiatric units (Kiesler, Simpkins, and Morton, In press). Some of these patients were treated in chemical dependency units, but the majority were treated in regular medical beds.

The HDS conducted by the National Center for Health Statistics (NCHS), and on which the above conclusions were based, contains some specialty psychiatric hospitals. In 1980, 13.5 percent of all inpatient episodes in the NCHS survey of short term hospitals occurred in the short term specialty hospitals, decreasing somewhat by 1985. Treatment in the specialty hospitals in this group averages in excess of 20 days. Treatment in the psychiatric unit has been stable at around 17 days; treatment outside the psychiatric unit has been stable at around 11 or 12 days. Differences in case mix account for some, but not all, of the differences in average length of stay. Length of stay in all three sites decreased somewhat in the period 1980-85.

Other Sites of Treatment

Multiservice mental health organizations provided 128,000 episodes of inpatient care in 1981 and 94,000 in 1986. Earlier data points are not available and since many of these organizations were formerly CMHCs, there is some overlap between those two categories. Average length of stay is not available, but is probably similar to the CMHCs (14 days). Residential treatment centers in 1972 (NIMH) had 29,000 episodes of inpatient care, which had increased to 47,000 by 1986. Data are not usually available for RTCs. Although RTCs do not have many known episodes nationally, they are important in the sense of accounting for a very substantial number of days of care, almost as many, for example, as private psychiatric hospitals. Their estimated average length of stay is well over a year, and perhaps as much as a year and a half (Kiesler and Sibulkin, 1987). The Indian Health Service also had 4,000 episodes of care (mostly for alcohol disorders) in 1983, and Army, Navy, and Air Force hospitals together accounted for 34,000 episodes of inpatient care.

In the general hospital system (treatment both in and out of units), commercial insurance provides about 45 percent of the days of care, followed by Medicare, and then Medicaid. In 1985, Medicaid paid for 2.5 million days of care in general hospitals, an increase of 40 percent over 1980 for Major Diagnostic Category (MDC) 19 (mental disorders). Medicaid provided for another 800,000 days of care for MDC-20 (alcohol and drug disorders) in 1985 (Kiesler and Simpkins, 1990).

Appendix E

Annotated Bibliography of Reviews and Studies
on Cost-Effectiveness of Alcohol, Drug Abuse,
and Mental Health (ADM) Services

Recent or frequently cited reviews or major studies of cost-offset, cost-effectiveness, or cost-benefits of alcohol, drug, or mental health treatment were reviewed. The focus of interest was on cost-effectiveness studies. Nevertheless, cost-offset or cost-benefit studies were included if they were landmark studies or if few cost-effectiveness studies existed.

The differences between cost-benefit, cost-offset, and cost-effectiveness studies are as follows:

1. Cost-benefit studies are those that assign a monetary value to all costs and benefits associated with a treatment. Costs include the actual program costs, costs to society (i.e., criminal justice, law enforcement, welfare, etc.), and costs to victims. Benefits include increased earnings (in dollars), decreased time away from work, decreased cost to society, and decreased costs to victims.

2. Cost-offset studies contrast a treatment group with a no treatment group and determine if the cost of the treatment is recovered by reduced costs for medical treatment in another part of the health care system.

3. Cost-effectiveness studies are those that calculate the cost of two or more treatment programs and use a common outcome measures for the programs examined. The outcome measure might be functional level, period of time since last alcohol or drug use, or any other outcome of relevance to the disorder. The different (two or more) treatment programs are then contrasted and compared on both the cost of providing the treatment and the outcome achieved by the treatment.

For each study or review presented below, the type of disorder or treatment it examines is identified. The nature of the study or review is briefly described along with problems that might limit the generalizability of results or the confidence that could be placed in the conclusions. Finally, a summary of the conclusions of the author(s) of the study or review is presented.

Reviews and Studies

Annis, H. M. (1986). "Is inpatient rehabilitation of the the alcoholic cost effective? Con Position." Advances in Alcohol and Substance Abuse, 5, 175-190.

Type of disorder/treatment: alcoholism.

The author reviewed recent (all were 1973 or later) studies that used controls and had random assignment to groups. Six studies were reported.
Problems with the studies. The author reported no particular problems with the six studies reported, although she did present a number of general cautionary statements.

Author's conclusions: "The empirical evidence overwhelmingly supports the following conclusions: (i) in hospital alcoholism programmes of a few weeks to a few months duration show no higher success rates than periods of brief hospitalization of a few days; (ii) the great majority of alcoholics seeking treatment for alcohol withdrawal can be safely detoxified without pharmacotherapy and in non-hospital-based units--detoxification with pharmacotherapy on an ambulatory basis has also been shown to be a safe alternative at one-tenth the cost; (iii) "partial hospitalization" (day treatment) programmes have been found to have equal or superior results to inpatient hospitalization at one-half to one-third the cost; (iv) well-controlled trials have also demonstrated that outpatient programmes can produce comparable results to inpatient programmes--one estimate places the cost saving at $3,700 per patient compared with the typical course of inpatient treatment; and (v) a growing body of evidence suggests that if patients could be matched on clinically significant dimensions to a range of treatment alternatives, much higher overall improvement rates in the alcoholism treatment field would be observed." (p. 189)

Apsler, R., & Harding, W. M. (1991). "Cost-effectiveness analysis of drug abuse treatment: Current status and recommendations for future research." In National Institute on Drug Abuse, Background Papers on Drug Abuse Financing and Services Research. Drug Abuse Services Research Series, No. 1, DHHS Pub. No. (ADM) 91-1777. Rockville, MD: National Institute on Drug Abuse.

Type of disorder/treatment. Drug abuse.

The authors searched 11 well known data bases for references dealing with drug abuse treatment outcomes from 1972 forward. The review appears to cover two national and 12-15 smaller studies as well as several reviews. It focuses on the methodological problems with existing research and directions for future research rather than cost-effectiveness per se.

Problems with the studies: The authors located five areas of difficulty with the studies. They questioned the validity of some of the measures, especially self-reports or medical records. The representativeness of the studies was often questionable, since most participants were not randomly assigned. It was often impossible to differentiate between treatment outcome and spontaneous outcome that may have resulted simply from deciding to undergo treatment. Undesired effects of treatment were not usually evaluated. How much treatment clients actually received frequently could not be determined.

Authors' conclusions: Existing research has serious shortcomings, but appears to be improving. Based on current information, the most prudent course is to assume that the least expensive treatment modalities are the most cost-effective. Wipespread use of inpatient care is not warranted.

Braun, P., Kochansky, G., Shapiro, R., Greenberg, S., Gudeman, J. E., Johnson, S., & Shore, M.F. (1981). "Overview: Deinstitutionalization of psychiatricpatients, a critical review of outcome studies." American Journal of Psychiatry, 138, 736-749.

Type of disorder/treatment: Mental disorders

The authors performed an extensive literature search for studies that included patient assignment to one or another treatment with preference given to randomization of experimental and control group. Studies were examined that met their criteria (assignment, patient characterization, experimental and control groups, outcomes measured, follow-up of sufficient numbers of the patients, and numbers of patients and the study group (N of cases)) and that could be characterized as alternatives to hospital admission, modifications of conventional hospitalization, or alternatives to continued long-term hospitalizations. The authors reported 30 studies published between 1960 and 1979 (only one study was in 1960, with the remainder published between 1967-1979).

Problems with the studies: Identified problems included potentially biased allocation of patients, insufficient information on confounding variables (such as drug therapy), and possible bias toward the experimental procedures.

Authors' conclusions: Patients who received treatment alternatives to hospitalization did not fare worse than those that were hospitalized, and in some cases they did better.

Cross, T., Saxe, L., & Hack, M. (1988). "The effectiveness of treatment settings for cocaine and other non-opiate drugs." Waltham, MA: Bigel Institute, Heller School, Brandeis University. (unpublished)

Type of disorder/treatment: alcohol/drug
The authors attempted to look at research using random assignment to treatment settings for nonopiate drug abuse. They only found one study that randomly assigned subjects to treatment and reported that it was "unrepresentative" of most patients and treatments. The review primarily examined studies of other types of abuse (opiate) and used them to make inferences about nonopiate abuse treatment. The authors reviewed three major research project studies (DARP, Treatment Outcome Prospective Study (TOPS), and the Philadelphia V.A. Medical Center's more than 10 years of research), and three additional research reports.

Problems with the studies: Some studies lacked random assignment to treatment groups. Time between the end of treatment and the followup assessments was not controlled in some studies. Often treatments being contrasted were in different communities and these effects were not controlled.

Authors' conclusions: "Treatment leads to more favorable outcomes than no treatment." "Little or no evidence supports the overall superiority of one treatment setting over another." "Long-term treatment appears necessary for many substance abusers." "Inpatient versus outpatient treatment is an inadequate dichotomy to describe current treatments. . . . The appropriate clinical decision is usually between inpatient treatment followed by outpatient treatment and outpatient treatment alone." (pp. 33-34)

Drug Abuse Reporting Program (DARP). Sells, S. B. (Ed.). (1974). Effectiveness of Drug Abuse Treatment (2 vols.). Cambridge, MA: Ballinger.

Sells, S. B., & Simpson, D. D. (Eds.). (1976). Effectiveness of Drug Abuse Treatment (3 vols.). Cambridge, MA: Ballinger.

Type of disorder/treatment: drug abuse

DARP studied approximately 44,000 admissions to 52 drug treatment programs from 1969 to 1973. The majority of all Federally supported programs were included in this study. Posttreatment followup was completed for almost 5,000 of the clients at 5-7 years after entrance into the program.

Problems with the study: Much of the data, and all of the followups, were self-reports without a corroborating source. It was difficult to locate clients who had left treatment. It is likely that the "better off" were more stable and easier to locate. Outcome measures may be more positive than those of patients who could not be located. Treatment received outside the DARP system was not controlled.

Authors' conclusions: (1) There were substantial reductions in daily opiate use from 70 percent before DARP to 35 percent a year or more after DARP. Comparable outcomes were found for methadone maintenance, therapeutic communities and outpatient drug-free programs. Each of these three programs was significantly better than the detoxification only, and the intake only (comparison) programs. Length of treatment of less than 90 days was ineffective.

Goldstein, M.S., Surber, M., & Wilner, D.M. (1984). "Outcome evaluations in substance abuse: A comparison of alcoholism, drug abuse and other mental health interventions." International Journal of the Addictions, 19(5), 479-502.

Type of disorder/treatment: Drug abuse.

The authors searched 50 major journals that were thought to have careful review procedures for outcome/evaluation studies that randomly assigned clients to treatment. A total of 234 studies focusing on drug abuse were included. The studies were published between 1969 and 1979.

Problems with the studies: Nearly half the studies employed no controls, only 15 used a design that included random assignment.

Authors' conclusions: Drug abuse studies employ the least adequate methodology and poorest measures. It is impossible to assess and compare outcomes and cost from the existing research.

Greenstree, R. L. (1988). Cost-Effective Alternatives in Alcoholism Treatment. Springfield, IL: Charles C. Thomas.

Type of disorder/treatment: Alcoholism.

The author performed an "exhaustive" study of literature published over the last 20 years (late 1960's-late 1980's). Forty-four unduplicated authors were referenced. The author contrasted medical (inpatient) detoxification with social-setting detoxification, and lengths of hospital based treatments.

Problems with the studies: The author states that the studies were "carefully designed, randomized, clinical trials." Beyond this statement little is said about the studies. Sample sizes are reported for each study, and were generally quite small (60-2,000).

Author's conclusions:

Medical vs. Social-Setting Detoxification. ". . . the evidence suggests that nonmedical personnel in a social setting can safely screen and monitor alcoholic patients. They do so at a cost which is dramatically less (15 percent to 25 percent of the per patient cost of medical, hospital- based detoxification), and they provide a friendly, motivating atmosphere which leads a greater percentage of patients to seek further, long-term treatment for their alcoholism." (p. 7)
Length of hospital stay. "..it would appear, at least from evidence generated from 1973 through 1983, that the beneficial elements of inpatient, hospital-based alcoholism treatment are conferred within the first nine days of treatment, on average. Assuming a typical detoxification stay of five days, an additional four days of hospital-based treatment is all that can be justified; treatment beyond that point would not be cost-effective." (p. 11)
Inpatient, hospital-based treatment vs day-clinic care. "The cost per 'successful' patient was computed to be $901.26 for the day clinic and $2,544.26 for the inpatient program. Thus the day clinic was only 35.4 percent as costly as the inpatient program." (p. 12)
Inpatient, hospital-based treatment vs partial-hospital treatment. "The total average cost of treatment for each inpatient was $4,359.27; for each partial-hospital patient, $2,700.74. Thus the average treatment cost for the partial-hospital patients was 61.9 percent of the average cost for the inpatients." (p. 12)

Holder, H. H. (1987). "Alcoholism treatment and potential health care cost saving." Medical Care, 25, 1-71.

Type of disorder/treatment: Alcoholism.

The author reviewed alcohol treatment research completed since the 1979 Jones & Vischi review, focusing on cost-offset. Six controlled studies and six naturalistic studies were included. The studies examined pretreatment and posttreatment medical cost.

Problems with the studies: None of the studies used randomly selected nontreatment (control) groups from the same population as the treatment groups. Some of the studies did not adjust for inflation.

Author's conclusions: "Taken as a group, the studies reviewed confirm the potential of alcoholism treatment to contribute to sustained reductions in total health care utilization and costs. They also suggest that reductions in posttreatment costs are likely to continue; i.e., a downward cost trend has been shown to continue into the fourth and fifth year following the start of alcoholism treatment. These reductions may occur regardless of the type of treatment method or provider. All studies that analyzed costs by type of alcoholism treatment found no statistically significant differences. For example, minimum treatments composed of intake interviews only or 'advice' have the same results as more extended forms of treatment." (p. 69)

Institute of Medicine. (1989). Prevention and Treatment of Alcohol Problems: Research Opportunities. Washington, DC: National Academy Press.

Type of disorder/treatment: Alcoholism

The report mentioned 250 studies published since 1980, 60 of which had controlled designs. The report focused on future directions for research, rather than cost-effectiveness demonstrated in existing research. Weaknesses of past research and the questions raised by that research are the major thrust of the report.

Author's conclusions: The report points to the need for further research in all areas of alcoholism treatment, but makes only one conclusion that is relevant to cost-effectiveness evaluation: "The overall effectiveness of treatment with unselected patients appears to be no different in residential versus nonresidential programs or in longer versus shorter inpatient programs. Although health care reimbursement systems have emphasized more expensive forms of treatment, studies to date fail to show an offsetting increase in overall effectiveness relative to less expensive alternative forms of intervention. Residential care may be differentially effective for individuals who are socially unstable (e.g., homeless, unemployed) as well as those who have more severe levels of alcohol dependence and psychopathology. Socially stable individuals without severe alcohol dependence or psychopathology appear to be treatable by less intensive approaches without compromising effectiveness and at substantially less cost. The validation of differential criteria for admission to various treatment settings and for flexible movement between them during the course of an individual's treatment is an important task for future research." (p. 198)

Jones, K. R., & Vischi, T. R. (1979). "Impact of alcohol, drug abuse and mental health treatment on medical care utilization: A review of the research literature." Medical Care, 17(Suppl.).

Type of disorder/treatment: ADM

The authors reviewed 22 studies of the cost-offset (authors termed these cost-effectiveness) due to ADM treatment. The studies were conducted during the late 1960's to the late 1970's (one was not yet completed at the time of the review). Twelve studies focused on alcohol treatment, and 10 on mental disorders. Populations included in the survey were those in employer-based programs and organized health care settings.

Problems with the studies: Studies failed to take treatment and medical care utilization outside the study program into account. They used nonequivalent comparison groups and failed to adjust for pretreatment medical utilization. They also followed the patients for a year or less, so long term outcomes could not be assessed.

Authors' conclusions: Of the 22 studies, 21 showed that medical care use decreased following alcohol/mental health treatment. There was a 46 percent reduction in medical care use following alcohol treatment and 26 percent after mental health treatment.

Kiesler, C. A., & Sibulkin, A. E. (1987). Mental Hospitalization: Myths and Facts About a National Crisis. Newbury Park: Sage Publication.

Type of disorder/treatment: Mental disorders

The authors reviewed the literature for true experiments involving random assignment to either inpatient in a mental hospital or alternative care. Fourteen studies were found meeting this criterion. The studies were reported over the 12-year period from 1967-1979.

Problems with the studies: Many studies did not include a description of what the hospital treatment was. There was a lack of detail on drugs used. Some studies failed to provide detailed descriptions of the alternative treatment.

Authors' conclusions: Patients assigned to hospital treatment were more likely to be readmitted to the hospital than alternative care patients. Alternative care seemed to be more effective than hospitalization and to cost less.

Miller, W. R., & Hester, R. K. (1986). "Inpatient alcoholism treatment. Who benefits?" American Psychologist, 41, 794-805.

Type of disorder/treatment: alcoholism

The authors examined 26 controlled comparison studies of alcoholism treatment costs and outcomes. The studies appeared to have been conducted between the early 1970's and mid-1980's.

Problems with the studies: Each of the studies could be faulted on specific methodologic grounds. Four relied on matching designs and may have produced pretreatment differences between the groups. Many studies examined multiple outcome variables without adjusting the significance criterion. Generalizability across some populations may be questionable.

Authors' conclusions: "Nevertheless, the controlled research to date, ranging across a variety of kinds of treatment and patient populations, has yielded not a single study to point to superior overall effectiveness of treatment in intensive residential settings.

To be sure, alcoholics treated in residential programs do improve, sometimes at impressive rates, but current data strongly question whether improvement in any way requires the expensive settings of residential care. . . . Post-treatment success appears to be more powerfully influenced by participation in outpatient aftercare and by other posttreatment life circumstances than by the intensive phase of residential treatment." (p. 802)

Plotnick, D. E., Adams, K. M., Hunter, H. R. et al. (1982). Alcoholic Treatment Programs Within Pre-Paid Group Practice HMOs: A Final Report, Contract No. ADM 281-80-004, prepared by the Group Health Association of America for the National Institute on Alcohol Abuse and Alcoholism, Alcohol, Drug Abuse, and Mental Health Administration, May 1982.

Type of disorder/treatment: alcoholism

This was probably the most extensive study conducted on the cost-effectiveness of alcoholism treatment. The study was conducted over a 7-year period (ending in 1982) in four HMOs. There were 2,000 subjects included in the study, of which 1,033 were alcoholics in treatment, and the remainder spouses and family members of the alcoholics, and a nonalcoholic control group matched to the alcoholic on age, sex and length of membership in the HMO. Most of the results were reported in terms of pretreatment/posttreatment differences.

Problems with the studies: Sample sizes were small for any HMO or site of treatment. HMOs had previously decided outpatient care was more cost-effective and no comparisons were made between outpatient and inpatient treatment. The control group was nonalcoholic so that different types of people were being compared rather than different treatments or even no treatment.

Authors' conclusions:

Cost-offset. Alcoholism outpatient treatment produced medical care offset in terms of pre and posttreatment medical care costs. Patients reduced their ambulatory health service use between 11 percent (for the first 6 months following treatment) and 30 percent (after 4 years). Emergency care use also decreased (from 31 percent to 9 percent after 6 months). Hospitalization rates after treatment was less clear. Some sites of treatment seemed to increase, while others decreased.

Cost-effectiveness. (The HMOs had previously determined that outpatient treatment was less expensive) The authors found that patients decreased their use of alcohol by 65 percent (6 months) to 70 percent (2 years) and increased the length of abstinence from 8 days at intake to 19-20 days throughout the 3-year followup.

Cost-benefits. Patients showed an improvement in work related measures (fewer reprimands, fewer days sick or absent from work).

Rufener, B. L., Rachal, J. V., & Cruze, A. M. (1977). Management Effectiveness Measures for NIDA Drug Abuse Treatment Programs. Vol. I: Cost Benefit Analysis. DHEW Pub. No. (ADM)77-423. Rockville, MD: National Institute on Drug Abuse.

Type of disorder/treatment. Drug abuse.

The authors estimated the costs and benefits of five types of drug treatment modalities, based on data from the Drug Abuse Reporting Program (DARP, see entry above).

Problems with the study: In addition to limitations with DARP (see above), the authors had to estimate many of the costs used in the study. However, they calculated benefit-cost ratios under different assumptions about number of abusers, relapse rate, discount rate, and effectiveness of different types of treatment.

Authors' conclusions: The costs per patient per year for the treatment modalities studied were as follows: methadone maintenance, $1,095; drug free outpatient, $2,372; therapeutic community, $5,292; detoxification-outpatient, $1,095; detoxification-inpatient, $28,105. The authors found that drug free outpatient treatment had the highest benefit-cost ratio regardless of the assumptions under which it was calculated. The lowest ratio was associated either with inpatient detoxification or therapeutic communities, depending upon the particular set of assumptions used.

Saxe, L., Dougherty, D., Esty, K., & Fine, M. (1983). The Effectiveness and Costs of Alcoholism Treatment. Health technology case study 22. Washington, DC: Congress of the United States, Office of Technology Assessment.

Type of disorder/treatment: alcoholism

The authors summarized reviews of effectiveness research from early 1900 (Voegtlin, W. L., & Lemere, F. "The treatment of alcohol addiction: A review of the literature," Quarterly Journal of the Studies of Alcohol, 2, 717, 1942) through the publication date. There appeared to be seven reviews of effectiveness research which were published in 1970 or later. The authors also briefly reviewed several studies on which other reviewers had based their conclusions. In total, (reviews and study reports) more than 300 research reports (reports and publications) were covered in this review.

Authors' conclusions: "The conclusion of many of these reviews is that treatment seems better than no treatment, but that methodological problems render it difficult to conclude that any specific treatment is more effective than any other. Importantly, however, various treatment--such as aversion conditioning or AA--have been shown to be effective for some patients under some conditions." (p. 53).

Saxe, L., & Goodman, L. (1988). "The effectiveness of outpatient vs. inpatient treatment: Updating the OTA report." Paper presented to the Prudential Insurance Co.; Roseland, NJ (circulated as Discussion Draft).

Type of disorder/treatment: alcoholism

The authors identified 10 controlled studies that had been completed or were in progress since their 1983 review (see Saxe, Dougherty, Esty, & Fine, 1983) that compared inpatient vs. outpatient treatment settings or that compared different outpatient treatments.

Problems with the studies: Small sample sizes.

Authors' conclusions: "The results of controlled research on length, intensity and setting of treatment are clear and consistent: More treatment is not better than less treatment; more intense treatment is not better than less intense treatment; and inpatient care is not better than outpatient." (p. 20)

Treatment Outcome Prospective Study (TOPS). Hubbard, R. L., Marsden, M. E., Rachal, J. V., Harwood, H. J., Cavanaugh, E. R., & Ginzburg, H. M. (1989). Drug Abuse Treatment: A National Study of Effectiveness. Chapel Hill: The University of North Carolina Press.

Type of disorder/treatment: drug abuse

The TOPS was the successor to DARP. Approximately 11,000 clients in 43 selected drug abuse treatment programs were interviewed between 1979-1981 upon admission to either an outpatient methadone maintenance program, therapeutic community, or outpatient drug-free program. Three annual admission cohorts were interviewed and samples of each were followed at 3 months, 1 year, 2 years, and 3-5 years after leaving treatment. The results were reported in terms of cost-benefits.

Problems with the study: The study relied on self-reports. Comparisons of self-reports and clinical records indicate that there was a tendency to underreport use of all drugs in the clinical setting.

Authors' conclusions: Treatment resulted in a substantial decrease in use/abuse of drugs but abstinence was achieved for relatively few. There were substantial declines in criminal activity and suicidal symptoms. Hubbard et al. estimated the costs for each type of treatment and the associated social/economic costs of drug/alcohol abuse based on 1979 values. They found that: "Overall, the costs of drug abuse to law-abiding citizens fell from $9,190 per drug abuser in the year before treatment to $7,379 per addict in the year after treatment, a decrease of about 20 percent. Comparable costs to society declined from $15,262 to $14,089, a decrease of about 8 percent." (p. 156) ["Law-abiding citizens" were the victims of crimes.] The average daily cost of drug abuse treatment was $18.50 in residential facilities and only $6 in outpatient methadone or outpatient drug-free programs. The authors did not make clear exactly what was included in the amounts given.

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